

# The MassHealth Drug List



# MassHealth Drug List

The MassHealth Drug List (“the List”) is an alphabetical list of commonly prescribed drugs and therapeutic class tables. The List specifies which drugs need prior authorization (PA) when prescribed for MassHealth members. The prior-authorization requirements specified in the List reflect MassHealth’s policy described in the pharmacy regulations and provider bulletins, as well as MassHealth’s and the Drug Utilization Review (DUR) Board’s review of drugs within certain therapeutic classes. The List also specifies the generic over-the-counter drugs that are payable under MassHealth. Additional information can be found in the section titled “Prior-Authorization Status of Drugs.”

The tables provide a view of drugs within their respective therapeutic classes, along with prior-authorization requirements and clinical information about the drug. **The tables may not include all medications, dosage forms, and combination products within that therapeutic class.** The clinical information included in the tables is not intended to be comprehensive prescribing information. Prescribers and pharmacists should review the List and its applicable therapeutic class table when prescribing a drug or filling a prescription for a MassHealth member.

Any drug that does not appear on the List requires prior authorization, except for drugs described in 130 CMR 406.413(B) “Limitations on Coverage of Drugs – Drug Exclusions,” which are not available to MassHealth adult members. Prescribers may request PA for such drugs for members under 21 years old to determine medical necessity (130 CMR 450.144(A)).

## Updates to the List

The updates to the List are effective immediately, unless otherwise specified. For medications that have new prior-authorization requirements, MassHealth’s policy permits an otherwise valid prescription written before the effective date to be filled for the life of the prescription without prior authorization. Nevertheless, MassHealth encourages prescribers to reevaluate the medication regimens of their MassHealth patients, and consider switching their MassHealth patients to a medication regimen that does not require prior authorization or discontinuing the affected medication(s), as soon as possible, if clinically appropriate.

MassHealth encourages the use of specialized prior authorization request forms for certain drugs or classes of drugs. These forms were created to help you provide the information MassHealth needs to evaluate your request. The specialized forms have the name of the drug or drug class in the title. If there is no specialized form, please use the standard Drug Prior Authorization Request form. All forms are available at [www.mass.gov/druglist](http://www.mass.gov/druglist).

## Future Updates

MassHealth may update the MassHealth Drug List as frequently as twice a month. MassHealth will update the List as necessary on the first business day of the month or 14 calendar days later, or both. To sign up for e-mail alerts that will notify you when the List has been updated, go to the MassHealth Drug List at <http://www.mass.gov/druglist>. Click on “Introduction to the MassHealth Drug List,” then click on “Subscribe to E-Mail Alerts,” in the Introduction section of the List and send the e-mail that automatically appears on your screen and you will be subscribed. To get a paper copy of an updated List, submit a written request to the following address or fax number.

Include your MassHealth provider number, address, and a contact name with your request. MassHealth Publications will send you the latest version of the List. You will need to submit another written request each time you want a paper copy.

## 1. Additions

The following newly marketed drugs have been added to the MassHealth Drug List.

alclometasone (generics)  
Alinia tablet (nitazoxanide) – **PA**  
citalopram (generics)  
Factive (gemifloxacin)  
Palladone (hydromorphone extended-release capsules) – **PA**  
Parcopa (carbidopa/levodopa, orally disintegrating tablet) – **PA**  
Sanctura (trospium)  
Vytorin (ezetimibe/simvastatin) – **PA**  
Zegerid (omeprazole) – **PA**

## 2. New FDA “A”-Rated Generics

The following FDA “A”-rated generic drugs have been added to the MassHealth Drug List. The brand name is now listed with a # symbol, to indicate that prior authorization is required for the brand.

### New FDA “A” – Rated Generic Drug

ciclopirox  
gabapentin – **PA > 18 years**  
medroxyprogesterone  
mercaptopurine  
mesalamine  
metoprolol/hydrochlorothiazide

### Generic Equivalent of

Loprox #  
Neurontin # – **PA > 18 years**  
Depo-Provera #  
Purinethol #  
Rowasa #  
Lopressor HCT #

## 3. Change in Prior Authorization Status

- a. MassHealth no longer requires prior authorization for the following medication for members under 18 years old.

paroxetine

- b. MassHealth requires prior authorization for the following medication, effective December 15, 2004.

Cipro XR (ciprofloxacin extended-release) – **PA**

## 4. Update to Prior Authorization Request Forms

The following prior-authorization request forms have been updated.

Antidepressant Prior Authorization Request Form  
Statin Prior Authorization Request

## 5. New or Revised Therapeutic Tables

Table 3 – Gastrointestinal Drugs – Histamine H<sub>2</sub> Antagonists/Proton Pump Inhibitors

Table 8 – Narcotic Agonist Analgesics

Table 13 – Statins

Table 16 – Topical Corticosteroids

Table 17 – Antidepressants

Table 20 – Anticonvulsants

Table 21 – Beta-Adrenergic Blocking Agents

## 6. Update to MassHealth Pharmacy Program Initiative

Antidepressant Initiative

(Please note: The Antidepressant Initiative is scheduled for revision, February 2005)

### Prior-Authorization Status of Drugs

Drugs may require prior authorization for a variety of reasons. MassHealth determines the prior-authorization status of drugs on the List on the basis of the following:

MassHealth program requirements; and  
ongoing evaluation of the drugs' utilization, therapeutic efficacy, safety, and cost.

Drugs are evaluated first on safety and effectiveness, and second on cost. Some drugs require prior authorization because MassHealth and the Drug Utilization Review Board have concluded that there are more cost-effective alternatives. With regard to all such drugs, MassHealth also has concluded that the more costly drugs have no significant clinically meaningful therapeutic advantage in terms of safety, therapeutic efficacy, or clinical outcome compared to those less-costly drugs used to treat the same condition.

Evaluation of a drug includes a thorough review by physicians and pharmacists using medical literature and consulting with specialists, other physicians, or both. References used may include *AHFS Drug Information*, *Drug Facts and Comparisons*, *Micromedex*, literature from peer-reviewed medical journals, *Drug Topics Red Book*, *Approved Drug Products with Therapeutic Equivalence Evaluations* (also known as the “Orange Book”), the *Massachusetts List of Interchangeable Drug Products*, and manufacturers' product information.

In general, MassHealth strongly advocates the use of generic drugs. However, because of prevailing federal patent and rebate regulations, new-to-market generic drugs may cost more than the brand-name equivalent. For this reason MassHealth may place a prior-authorization requirement on these generic drugs. This prior-authorization requirement typically lasts for six months, until the generic price drops.

### List Conventions

The List uses the following conventions:

Brand-name products are capitalized. Generic products are in lowercase.

Formulations of a drug (for example, salt forms, sustained release, or syrups) are not specified on the List, unless a particular formulation requires prior authorization.

Combination products are listed with the individual ingredients separated by a slash mark (/).

Only the generic names of over-the-counter drugs that are payable under MassHealth appear on the List.

The brand names of such drugs are not listed, and therefore require prior authorization.

Only the generic names of antihistamine/decongestant combinations are listed. The brand names of such combinations are not listed, and therefore require prior authorization.

## **Drug List on the MassHealth Web Site**

The MassHealth Drug List can be found at [www.mass.gov/druglist](http://www.mass.gov/druglist). It can also be accessed from our home page at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

## **Questions or Comments**

Pharmacists and prescribers who have questions or comments about the MassHealth Drug List may contact the Drug Utilization Review Program at 1-800-745-7318 or may e-mail the MassHealth Pharmacy Program at [masshealthdruglist@nt.dma.state.ma.us](mailto:masshealthdruglist@nt.dma.state.ma.us). MassHealth does not answer all e-mail inquiries directly, but will use these inquiries to develop frequently asked questions about the MassHealth Drug List for its Web site.

When e-mailing a question or comment to the above e-mail address, please include your name, title, phone number, and fax number. This electronic mailbox should be used only for submitting questions or comments about the MassHealth Drug List. You will receive an automated response that acknowledges receipt of your e-mail. If you do not receive an automated reply, please resubmit your inquiry.

If a member has questions about the MassHealth Drug List, please refer the member to the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

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# Alphabetic List

## A

A/B Otic (antipyrine/benzocaine)

abacavir

abacavir/lamivudine

abacavir/lamivudine/zidovudine

abarelix – **PA**

Abelcet (amphotericin B)

Abilify (aripiprazole) – see Table 24, p. 58

acarbose – **PA**; see Table 26, p. 60

Accolate (zafirlukast) – **PA > 16 years**

AccuNeb (albuterol) – see Table 23, p. 57

Accupril (quinapril) – **PA**; see Table 18, p. 52

Accuretic (quinapril/hydrochlorothiazide) – **PA**;  
see Table 18, p. 52

Accutane # (isotretinoin) – see Table 10, p. 44

Accuzyme (papain/urea)

acebutolol – see Table 21, p. 55

Aceon (perindopril) – **PA**; see Table 18, p. 52

acetaminophen \*

Acetasol # (acetic acid)

acetazolamide

acetic acid

acetohexamide – see Table 26, p. 60

acetohydroxamic acid

acetylcysteine

Achromycin # (tetracycline)

Aciphex (rabeprazole) – **PA**; see Table 3, p. 37

acitretin – see Table 10, p. 44

Aclovate (alclometasone) – **PA**; see Table 16,  
p. 50

Acova (argatroban) – **PA**

acrivastine/pseudoephedrine – **PA**; see  
Table 12, p. 46

Acthar (corticotropin)

Acticin (permethrin)

Actigall # (ursodiol)

Actimmune (interferon gamma-1b) – see  
Table 5, p. 39

Actiq (fentanyl transmucosal system) – **PA**; see  
Table 8, p. 42

Activella (estradiol/norethindrone)

Actonel (risedronate)

Actos (pioglitazone) – see Table 26, p. 60

Acular (ketorolac)

acyclovir

A&D, topical \*

Adalat # (nifedipine) – see Table 22, p. 56

adalimumab – **PA**; see Table 5, p. 39

adapalene – **PA > 25 years**; see Table 10, p. 44

Adderall # (amphetamine salts)

adefovir

Adoxa (doxycycline)

Adrenalin (epinephrine)

Adriamycin # (doxorubicin)

Adrucil # (fluorouracil)

Advair (fluticasone/salmeterol) – see Table 23, p. 57

Advate (antihemophilic factor, recombinant)

Advicor (lovastatin/niacin) – **PA**; see Table 13, p. 47

AeroBid (flunisolide) – see Table 23, p. 57

AeroBid-M (flunisolide) – **PA**; see Table 23, p. 57

agalsidase – **PA**

Agenerase (amprenavir)

Aggrenox (dipyridamole/aspirin)

Agrylin (anagrelide)

A-Hydrocort # (hydrocortisone)

Ak-beta (levobunolol)

Akineton (biperiden)

Akne-Mycin (erythromycin)

Ak-Pentolate # (cyclopentolate)

Ak-Polybac # (bacitracin/polymyxin B)

Ak-Spore HC # (neomycin/polymyxin B/  
hydrocortisone)

Ak-Sulf # (sulfacetamide)

Aktob # (tobramycin)

Ak-tracin # (bacitracin)

Ak-Trol # (neomycin/polymyxin B/  
dexamethasone)

Alamast (pemirolast)

albendazole

Albenza (albendazole)

albumin

Albuminar-25 (albumin)

albuterol

albuterol, inhalation solution; see Table 23, p. 57

albuterol, ° inhaler – see Table 23, p. 57

albuterol/ipratropium, inhalation solution – see  
Table 23, p. 57

albuterol/ipratropium, inhaler – see Table 23, p. 57

alclometasone ° – see Table 16, p. 50

Aldactazide # (spironolactone/hydrochlorothiazide)

Aldactone # (spironolactone)

Aldara (imiquimod)

Aldoril-25 # (methyldopa/hydrochlorothiazide)

Aldurazyme (laronidase) – **PA**

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**\*** The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

**°** Prior-authorization status depends on the drug’s formulation.

Note: Any drug that does not appear on the List requires prior authorization.



## Alphabetic List (cont.)

alefacept – **PA**; see Table 5, p. 39  
alendronate  
Alesse # (ethinyl estradiol/levonorgestrel)  
Alferon N (interferon alfa-n3, human leukocyte derived) – see Table 5, p. 39  
alfuzosin – **PA**; see Table 19, p. 53  
Alimta (pemetrexed)  
Alinia suspension (nitazoxanide) – **PA > 12 years**  
Alinia tablet (nitazoxanide) – **PA**  
alitretinoin – **PA**; see Table 10, p. 44  
Akeran (melphalan)  
Allegra (fexofenadine) – **PA**; see Table 12, p. 46  
Allegra-D (fexofenadine/pseudoephedrine) – **PA**; see Table 12, p. 46  
Allergen (benzocaine/antipyrine)  
allopurinol  
almotriptan – **PA > 6 units/month**; see Table 14, p. 48  
Alocril (nedocromil)  
Alomide (Iodoxamide)  
Alora # (estradiol)  
alosetron – **PA**  
Aloxi (palonosetron)  
Alphagan (brimonidine)  
Alphanate (antihemophilic factor, human)  
AlphaNine SD (factor IX, human)  
alpha1–proteinase inhibitor–human  
alprazolam  
alprazolam extended-release – **PA**  
alprostadil – **PA**; see Table 6, p. 40  
Alrex (loteprednol)  
Altace (ramipril) – **PA**; see Table 18, p. 52  
Altinac (tretinoin) – **PA > 25 years**  
Altacor (lovastatin extended-release) – **PA**; see Table 13, p. 47  
Altoprev (lovastatin extended-release) – **PA**; see Table 13, p. 47  
aluminum carbonate \*  
aluminum chloride  
aluminum hydroxide \*  
Alupent # (metaproterenol), inhalation solution – see Table 23, p. 57  
Alupent (metaproterenol), inhaler – **PA**; see Table 23, p. 57  
amantadine  
Amaryl (glimepiride) – **PA**; see Table 26, p. 60

Ambien (zolpidem) – **PA > 10 units/month**; see Table 15, p. 49  
Ambisome (amphotericin B)  
amcinonide – see Table 16, p. 50  
Amerge (naratriptan) – **PA**; see Table 14, p. 48  
Americaine # (benzocaine)  
A-Methapred # (methylprednisolone)  
Amevive (alefacept) – **PA**; see Table 5, p. 39  
Amicar # (aminocaproic acid)  
amikacin  
amiloride  
amiloride/hydrochlorothiazide  
Amino Acid Cervical (urea/sodium propionate/methionine/cystine/inositol)  
amino acid & electrolyte IV infusion  
aminocaproic acid  
Amino-Cerv pH 5.5 (urea/sodium propionate/methionine/cystine/inositol)  
aminoglutethimide  
aminophylline  
amiodarone  
amitriptyline – see Table 17, p. 51  
amitriptyline/chlordiazepoxide  
amitriptyline/perphenazine  
amlodipine – **PA**; see Table 22, p. 56  
amlodipine/atorvastatin – **PA**; see Table 13, p. 47; see Table 22, p. 56  
amlodipine/benazepril – **PA**; see Table 18, p. 52; see Table 22, p. 56  
ammonium lactate °  
amoxapine – see Table 17, p. 51  
amoxicillin  
amoxicillin/clavulanate  
Amoxil # (amoxicillin)  
amphetamine salts  
amphotericin B  
ampicillin  
ampicillin/sulbactam  
amprenavir  
amrinone  
amylase/lipase/protease  
Anadrol-50 (oxymetholone)  
Anafranil # (clomipramine) – see Table 17, p. 51  
anagrelide  
anakinra – **PA**; see Table 5, p. 39  
Anaprox # (naproxen) – see Table 11, p. 45  
Anaspaz # (hyoscyamine)  
anastrozole

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**#** This is a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

**\*** The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

**°** Prior-authorization status depends on the drug’s formulation.

Note: Any drug that does not appear on the List requires prior authorization.

## **Alphabetic List (cont.)**

Ancef # (cefazolin)  
Ancobon (flucytosine)  
Androderm (testosterone)  
Androgel (testosterone)  
Android (methyltestosterone)  
Anexsia # (hydrocodone/acetaminophen) – see Table 8, p. 42  
Anolor-300 (butalbital/acetaminophen/cafeine)  
Ansaid # (flurbiprofen) – see Table 11, p. 45  
Antabuse (disulfiram)  
anthralin  
antihemophilic factor, human  
anithemophilic factor, recombinant  
anti-inhibitor coagulant complex  
antipyrine/benzocaine  
antithymocyte globulin, equine – see Table 1, p. 35  
antithymocyte globulin, rabbit – see Table 1, p. 35  
Antivert # (meclizine)  
Anusol-HC # (hydrocortisone) – see Table 16, p. 50  
Anzemet (dolasetron) – **PA > 15 units/month**;  
See Table 27, p. 61  
APF # (sodium fluoride)  
Aphthasol 5% (amlexanox)  
apraclonidine  
aprepitant – **PA > 3 units/14 days**  
Apri (ethinyl estradiol/desogestrel)  
Apokyn (apomorphine)  
apomorphine  
Aqua-Mephyton # (phytonadione)  
Aralast (alpha<sub>1</sub>-proteinase inhibitor-human)  
Aralen Hydrochloride (chloroquine)  
Aralen Phosphate # (chloroquine)  
Aranesp (darbepoetin) – **PA**; see Table 4, p. 38  
Arava (leflunomide)  
Aredia # (pamidronate)  
argatroban – **PA**  
Aricept (donepezil)  
Arimidex (anastrozole)  
aripiprazole – see Table 24, p. 58  
Aristocort (triamcinolone)  
Aristocort # (triamcinolone), topical – see Table 16, p. 50  
Aristocort A # (triamcinolone) – see Table 16, p. 50  
Aristocort Forte (triamcinolone)  
Aristospan (triamcinolone)  
Arixtra (fondaparinux) – **PA > 11 doses/Rx**  
Aromasin (exemestane)  
Artane # (trihexyphenidyl)  
Arthrotec (diclofenac/misoprostol) – **PA < 60 years**;  
see Table 11, p. 45  
artificial tears \*  
Asacol (mesalamine)  
ascorbic acid \*  
aspirin \*  
aspirin/buffers \*  
Astelin (azelastine) – **PA > 1 inhaler/month**; see Table 12, p. 46  
Astramorph PF (morphine) – see Table 8, p. 42  
Atacand (candesartan) – **PA**; see Table 18, p. 52  
Atarax # (hydroxyzine) – see Table 12, p. 46  
atazanavir  
atenolol – see Table 21, p. 55  
atenolol/chlorthalidone – see Table 21, p. 55  
Atgam (antithymocyte globulin, equine) – see Table 1, p. 35  
Ativan # (lorazepam)  
atomoxetine – **PA**  
atorvastatin – **PA > 30 units/month**; see Table 13, p. 47  
atovaquone  
atovaquone/proguanil  
atropine  
Atrovent (ipratropium), inhalation solution – see Table 23, p. 57  
Atrovent (ipratropium), inhaler – see Table 23, p. 57  
Atrovent (ipratropium), nasal spray  
augmented betamethasone ° – see Table 16, p. 50  
Augmentin (amoxicillin/clavulanate)  
Auralgan # (antipyrine/benzocaine)  
auranofin  
Aurodex (antipyrine/benzocaine)  
Aurolate (gold sodium thiomalate)  
aurothioglucose  
Auroto # (antipyrine/benzocaine)  
Avalide (irbesartan/hydrochlorothiazide) – **PA**; see Table 18, p. 52  
Avandamet (rosiglitazone/metformin) – **PA**;  
see Table 26, p. 60  
Avandia (rosiglitazone) – see Table 26, p. 60  
Avapro (irbesartan) – **PA**; see Table 18, p. 52  
Avastin (bevacizumab)  
AVC # (sulfanilamide)

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**°** Prior-authorization status depends on the drug's formulation.

Note: Any drug that does not appear on the List requires prior authorization.

## Alphabetic List (cont.)

Avelox (moxifloxacin)  
Aventyl # (nortriptyline) – see Table 17, p. 51  
Aviane # (ethinyl estradiol/levonorgestrel)  
Avinza (morphine extended-release) – **PA**; see Table 8, p. 42  
Avita # (tretinoin) – **PA > 25 years**; see Table 10, p. 44  
Avodart (dutasteride) – **PA**  
Avonex (interferon beta-1a) – see Table 5, p. 39  
Axert (almotriptan) – **PA > 6 units/month**; see Table 14, p. 48  
Axid (nizatidine) – **PA**; see Table 3, p. 37  
Axocet # (butalbital/acetaminophen)  
Aygestin # (norethindrone)  
azacitidine  
Azactam (aztreonam)  
azatadine – **PA**; see Table 12, p. 46  
azatadine/pseudoephedrine – **PA**; see Table 12, p. 46  
azathioprine  
azelaic acid  
azelastine – **PA > 1 inhaler/month**; see Table 12, p. 46  
Azelex (azelaic acid)  
azithromycin  
Azmacort (triamcinolone) – see Table 23, p. 57  
Azopt (brinzolamide)  
aztreonam  
Azulfidine # (sulfasalazine)

## B

bacitracin \*  
bacitracin/polymyxin B  
baclofen – see Table 7, p. 41  
baclofen intrathecal – **PA**; see Table 7, p. 41  
Bactrim # (trimethoprim/sulfamethoxazole)  
Bactroban (mupirocin)  
balsalazide  
Banflex (orphenadrine) – see Table 7, p. 41  
BayHep B (hepatitis B immune globulin, human) – see Table 1, p. 35  
BayRab (rabies immune globulin IM, human) – see Table 1, p. 35  
BayRho-D Full Dose (Rho(D) immune globulin IM) – see Table 1, p. 41  
BayRho-D Mini Dose (Rho(D) immune globulin IM, micro-dose) – see Table 1, p. 35

BayTet (tetanus immune globulin IM, human) – see Table 1, p. 35  
BCG vaccine  
Bebulin VH Immuno (factor IX complex)  
becaplermin  
beclomethasone, inhaler – see Table 23, p. 57  
beclomethasone, nasal spray – **PA > 1 inhaler/month**; see Table 25, p. 59  
Beconase AQ (beclomethasone, nasal spray) – **PA > 1 inhaler/month**; see Table 25, p. 59  
belladonna/phenobarbital  
Benadryl # (diphenhydramine) – see Table 12, p. 46  
benazepril – see Table 18, p. 52  
BeneFix (factor IX, recombinant)  
Benicar (olmesartan) – **PA**; see Table 18, p. 52  
Bentyl # (dicyclomine)  
Benzacilin (benzoyl peroxide/clindamycin)  
Benzamycin (benzoyl peroxide/erythromycin)  
benzocaine  
benzoyl peroxide °  
benzoyl peroxide/clindamycin  
benzoyl peroxide/erythromycin  
benzoyl peroxide/hydrocortisone  
benzoyl peroxide/sulfur  
benztropine  
bepridil – **PA**; see Table 22, p. 56  
Betagan # (levobunolol)  
betaine  
betamethasone  
betamethasone, topical ° – see Table 16, p. 50  
Betapace # (sotalol) – see Table 21, p. 55  
Betaseron (interferon beta 1-b) – see Table 5, p. 39  
Beta-Val # (betamethasone) – see Table 16, p. 50  
betaxolol – see Table 21, p. 55  
bethanechol  
Betimol (timolol)  
bevacizumab  
bexarotene  
Bextra (valdecoxib) – **PA < 60 years**; see Table 11, p. 45  
Bexxar (tositumomab) – **PA**  
Biaxin (clarithromycin)  
bicalutamide  
Bicitra (sodium citrate/citric acid)  
bimatoprost  
biperiden  
bisacodyl \*  
bismuth subsalicylate \*

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**°** Prior-authorization status depends on the drug’s formulation.

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## Alphabetic List (cont.)

bismuth subsalicylate/tetracycline/metronidazole  
bisoprolol – see Table 21, p. 55  
bisoprolol/hydrochlorothiazide – see Table 21, p. 55  
bleomycin  
Bleph-10 # (sulfacetamide)  
Blephamide (sulfacetamide/prednisolone)  
Blocadren # (timolol) – see Table 21, p. 55  
bortezomib  
bosentan  
Botox (botulinum toxin type A) – **PA**  
botulinum toxin type A – **PA**  
botulinum toxin type B – **PA**  
Brethine # (terbutaline)  
Brevibloc (esmolol) – see Table 21, p. 55  
Brevicon (ethinyl estradiol/norethindrone)  
brimonidine  
brinzolamide  
bromocriptine  
brompheniramine \* – see Table 12, p. 46  
brompheniramine/pseudoephedrine \* – see Table 12, p. 46  
budesonide, inhalation suspension – see Table 23, p. 57  
budesonide, inhaler – see Table 23, p. 57  
budesonide, nasal spray – **PA > 1 inhaler/2 months**; see Table 25, p. 59  
bumetanide  
Bumex # (bumetanide)  
Buphenyl (sodium phenylbutyrate)  
bupivacaine  
Buprenex (buprenorphine)  
buprenorphine  
buprenorphine/naloxone  
bupropion – see Table 17, p. 51  
bupropion extended-release tablets – **PA**; see Table 17, p. 51  
bupropion sustained release – see Table 17, p. 51  
Buspar # (buspirone)  
buspirone  
butabarbital  
butalbital  
butalbital/acetaminophen  
butalbital/acetaminophen/caffeine  
butalbital/acetaminophen/codeine/caffeine  
butalbital/aspirin/caffeine  
butalbital/aspirin/codeine/caffeine

butenafine  
Butisol (butabarbital)  
butoconazole  
butorphanol, injection  
butorphanol, nasal spray – **PA**

## C

Cabergoline  
Caduet (amlodipine/atorvastatin) – **PA**; see Table 13, p. 47; see Table 22, p. 56  
Cafcit (caffeine)  
caffeine  
Cafergot (ergotamine/caffeine)  
calamine lotion \*  
Calan # (verapamil) – see Table 22, p. 56  
calcifediol  
Calciferol (ergocalciferol)  
Calcijex (calcitriol)  
calcipotriene  
calcitonin, human  
calcitonin, salmon  
calcitriol  
calcium acetate  
calcium carbonate \*  
calcium citrate \*  
calcium glubionate \*  
calcium gluconate \*  
calcium phosphate \*  
Calderol (calcifediol)  
Camptosar (irinotecan)  
Cancidas (caspofungin)  
candesartan – **PA**; see Table 18, p. 52  
Cantil (mepenzolate)  
capecitabine  
Capex (fluocinolone) – **PA**; see Table 16, p. 50  
Capitol (chloroxine)  
Capoten # (captopril) – see Table 18, p. 52  
Capozide # (captopril/hydrochlorothiazide) – see Table 18, p. 52  
capsaicin \*  
captopril – see Table 18, p. 52  
captopril/hydrochlorothiazide – see Table 18, p. 52  
Carac (fluorouracil)  
Carafate # (sucralfate)  
carbamazepine – see Table 20, p. 54  
carbamide peroxide \*  
Carbatrol (carbamazepine) – see Table 20, p. 54

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## Alphabetic List (cont.)

carbenicillin  
carbidopa  
carbidopa/levodopa  
carbidopa/levodopa, orally disintegrating tablet  
– **PA**  
carbidopa/levodopa/entacapone – **PA**  
carbinoxamine – see Table 12, p. 46  
carbinoxamine/pseudoephedrine – see Table 12, p. 46  
carboplatin  
Cardene # (nicardipine) – see Table 22, p. 56  
Cardizem # (diltiazem) – see Table 22, p. 56  
Cardura # (doxazosin) – see Table 19, p. 53  
Carimune (immune globulin IV, human) – **PA**;  
see Table 1, p. 35  
carisoprodol – see Table 7, p. 41  
Carmol (urea)  
Carnitor (levocarnitine)  
carteolol, ophthalmic  
carteolol, oral – **PA**; see Table 21, p. 55  
Cartia (diltiazem) – see Table 22, p. 56  
Cartrol (carteolol) – **PA**; see Table 21, p. 55  
carvedilol – **PA**; see Table 21, p. 55  
casanthranol \*  
Casodex (bicalutamide)  
caspofungin  
castor oil/peru balsam/trypsin  
Cataflam # (diclofenac)  
Catapres # (clonidine)  
Caverject (alprostadil) – **PA**; see Table 6, p. 40  
Cebocap (lactose)  
Ceclor # (cefaclor)  
Cedax (ceftibuten)  
Ceenu (lomustine)  
cefaclor  
cefadroxil  
cefazolin  
cefdinir  
cefditoren  
cefepime  
cefixime  
Cefizox (ceftizoxime)  
Cefotan (cefotetan)  
cefotaxime  
cefotetan  
cefoxitin  
cefpodoxime  
cefprozil

ceftazidime  
ceftibuten  
Ceftin # (cefuroxime)  
ceftizoxime  
ceftriaxone  
cefuroxime  
Cefzil (cefprozil)  
Celebrex (celecoxib) – **PA < 60 years**; see Table 11, p. 45  
celecoxib – **PA < 60 years**; see Table 11, p. 45  
Celestone (betamethasone)  
Celexa (citalopram) – **PA**; see Table 17, p. 51  
Cellcept (mycophenolate)  
Celontin (methsuximide) – see Table 20, p. 54  
Cenestin (estrogens, conjugated)  
cephalexin  
Cephulac # (lactulose)  
Cerezyme (imiglucerase)  
Cerumenex (triethanolamine)  
cetirizine syrup – **PA > 12 years (except for LTC members)**; see Table 12, p. 46  
cetirizine tablets – **PA**; see Table 12, p. 46  
cetirizine/pseudoephedrine – **PA**; see Table 12, p. 46  
cetuximab  
cevimeline  
Chemet (succimer)  
chloral hydrate  
chlorambucil  
chloramphenicol  
chlordiazepoxide  
chlorhexidine gluconate \*  
Chloroptic # (chloramphenicol)  
chloroquine  
chlorothiazide  
chloroxine  
chloroxylenol/pramoxine/hydrocortisone  
chlorpheniramine \* – see Table 12, p. 46  
chlorpheniramine/phenylephrine – see Table 12, p. 46  
chlorpheniramine/pseudoephedrine \* – see Table 12, p. 46  
chlorpheniramine/pyrilamine/phenylephrine – see Table 12, p. 46  
chlorpromazine  
chlorpropamide – see Table 26, p. 60  
chlorthalidone  
chlorzoxazone

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## Alphabetic List (cont.)

cholestyramine  
choline salicylate/magnesium salicylate  
Cialis (tadalafil) – **PA**; see Table 6, p. 40  
Cibacalcin (calcitonin, human)  
ciclopirox  
cidofovir  
cilostazol  
Ciloxan (ciprofloxacin)  
cimetidine \* – see Table 3, p. 37  
cinacalcet – **PA**  
Cinobac (cinoxacin)  
cinoxacin  
Cipro # (ciprofloxacin)  
Cipro XR (ciprofloxacin extended-release) – **PA**  
(effective 12/15/04)  
ciprofloxacin  
ciprofloxacin extended-release – **PA**  
cisplatin  
citalopram ° – see Table 17, p. 51  
citrate salts  
Claforan # (cefotaxime)  
Clarinox (desloratadine) – **PA**; see Table 12,  
p. 46  
clarithromycin  
clemastine – see Table 12, p. 46  
Cleocin # (clindamycin)  
Climara # (estradiol)  
Clindagel (clindamycin)  
clindamycin °  
Clindets # (clindamycin)  
Clinoril # (sulindac) – see Table 11, p. 45  
clobetasol ° – see Table 16, p. 50  
clocortolone – **PA**; see Table 16, p. 50  
Cloderm (clocortolone) – **PA**; see Table 16,  
p. 50  
clomipramine – see Table 17, p. 51  
clonazepam – see Table 20, p. 54  
clonazepam, orally disintegrating tablets – **PA**;  
see Table 20, p. 54  
clonidine  
clonidine/chlorthalidone  
clopidogrel  
clorazepate – see Table 20, p. 54  
Clorpres (clonidine/chlorthalidone)  
clotrimazole \*  
clotrimazole/betamethasone  
clozapine – see Table 24, p. 58  
clozapine, orally disintegrating tablet – **PA**  
Clozaril # (clozapine) – see Table 24, p. 58  
cod liver oil \*  
codeine – **PA** > 360 mg/day; see Table 8, p. 42  
codeine/acetaminophen – see Table 8, p. 42  
codeine/aspirin – see Table 8, p. 42  
Cogentin # (benztropine)  
Cognex (tacrine)  
Colazal (balsalazide)  
colchicine/probenecid  
colesevelam  
Colestid (colestipol)  
colestipol  
colistimethate  
colistin/hydrocortisone/neomycin  
collagenase  
colloidal oatmeal \*  
Col-Probenecid # (colchicine/probenecid)  
Coly-Mycin (colistimethate)  
CoLyte # (polyethylene glycol-electrolyte solution)  
Combipatch (estradiol/norethindrone)  
Combipres (clonidine/chlorthalidone)  
Combivent (albuterol/ipratropium) – see  
Table 23, p. 57  
Combivir (lamivudine/zidovudine)  
Compazine # (prochlorperazine)  
Compro (prochlorperazine)  
Comtan (entacapone)  
Concerta (methylphenidate)  
Condylox (podofilox)  
Constulose (lactulose)  
Copaxone (glatiramer)  
Copegus (ribavirin)  
copper IUD  
Cordarone # (amiodarone)  
Cordan (flurandrenolide) – **PA**; see Table 16, p. 50  
Coreg (carvedilol) – **PA**; see Table 21, p. 55  
Corgard # (nadolol) – see Table 21, p. 55  
Cormax # (clobetasol) – see Table 16, p. 50  
Cortane-B (chloroxylenol/pramoxine/  
hydrocortisone)  
Cortef # (hydrocortisone)  
corticotropin  
Cortifoam (hydrocortisone)  
cortisone  
Cortisporin # (neomycin/polymyxin B/  
hydrocortisone)  
Cortisporin-TC (colistin/hydrocortisone/neomycin)

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## Alphabetic List (cont.)

Cortomycin (neomycin/polymyxin B/  
hydrocortisone)  
Cortrosyn (cosyntropin)  
Corzide (nadolol/bendroflumethiazide) – see  
Table 21, p. 55  
Cosopt (dorzolamide/timolol)  
cosyntropin  
Coumadin # (warfarin)  
Covera-HS (verapamil) – see Table 22, p. 56  
Cozaar (losartan) – **PA**; see Table 18, p. 52  
Creon (amylase/lipase/protease)  
Crestor (rosuvastatin) – **PA > 30 units/month**;  
see Table 13, p. 47  
Crixivan (indinavir)  
Crolom (cromolyn)  
cromolyn  
cromolyn, inhalation solution – see Table 23,  
p. 57  
cromolyn, inhaler – see Table 23, p. 57  
crotamiton  
Cubicin (daptomycin)  
Cuprimine (penicillamine)  
Cutivate # (fluticasone) – see Table 16,  
p. 50  
cyanocobalamin °  
cyanocobalamin/folic acid – **PA**  
Cyclessa # (ethinyl estradiol/desogestrel)  
cyclobenzaprine – see Table 7, p. 41  
Cyclocort # (amcinonide) – see Table 16, p. 50  
Cyclogyl # (cyclopentolate)  
Cyclomydril (cyclopentolate/phenylephrine)  
cyclopentolate  
cyclopentolate/phenylephrine  
cyclophosphamide  
cyclosporine  
Cylert # (pemoline)  
Cymbalta (duloxetine) – **PA**; see Table 17, p. 51  
cyproheptadine – see Table 12, p. 46  
Cystadane (betaine)  
Cystagon (cysteamine)  
cysteamine  
Cystospaz # (hyoscyamine)  
Cytadren (aminogluthethimide)  
cytarabine  
CytoGam (cytomegalovirus immune globulin IV,  
human) – see Table 1, p. 35  
cytomegalovirus immune globulin IV, human –  
see Table 1, p. 35

Cytomel (liothyronine)  
Cytosar-U # (cytarabine)  
Cytotec # (misoprostol)  
Cytovene (ganciclovir)  
Cytoxan # (cyclophosphamide)  
Cytra-2 (sodium citrate/citric acid)  
Cytra-3 (potassium citrate/sodium citrate/citric acid)  
Cytra-K (potassium citrate/citric acid)

## D

dacarbazine  
daclizumab  
Dalmane # (flurazepam) – **PA > 10 units/month**;  
see Table 15, p. 49  
dalteparin  
danazol  
Danocrine # (danazol)  
Dantrium (dantrolene)  
dantrolene  
dapsone  
daptomycin  
Daranide (dichlorphenamide)  
Daraprim (pyrimethamine)  
darbepoetin alpha – **PA**; see Table 4, p. 38  
Darvocet-N # (propoxyphene napsylate/  
acetaminophen) – see Table 8, p. 42  
Darvon # (propoxyphene) – see Table 8, p. 42  
Darvon-N (propoxyphene napsylate) – see Table 8,  
p. 42  
daptomycin  
Daypro # (oxaprozin) – see Table 11, p. 45  
DDAVP # (desmopressin)  
Deca-Durabolin (nandrolone)  
Declomycin (demeclocycline)  
deferroxamine  
Delatestryl (testosterone)  
delavirdine  
Delestrogen # (estradiol)  
Deltasone # (prednisone)  
Demadex # (torsemide)  
demeclocycline  
Demerol # (meperidine) – **PA > 750 mg/day**; see  
Table 8, p. 42  
Demser (metyrosine)  
Demulen # (ethinyl estradiol/ethynodiol)  
Denavir (penciclovir)  
Depacon (valproate) – see Table 20, p. 54

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## Alphabetic List (cont.)

Depakene # (valproic acid) – see Table 20, p. 54  
Depakote (divalproex) – see Table 20, p. 54  
Depen (penicillamine)  
Depo-Estradiol (estradiol)  
Depo-Medrol # (methylprednisolone)  
Deponit (nitroglycerin)  
Depo-Provera # (medroxyprogesterone)  
Depo-Testosterone # (testosterone)  
Derma-Smoother/FS (fluocinolone) – **PA**; see Table 16, p. 50  
Dermatop (prednicarbate) – **PA**; see Table 16, p. 50  
Desferal (deferoxamine)  
desipramine – see Table 17, p. 51  
desloratadine – **PA**; see Table 12, p. 46  
desmopressin  
Desogen # (ethinyl estradiol/desogestrel)  
desonide – see Table 16, p. 50  
DesOwen # (desonide) – see Table 16, p. 50  
desoximetasone – see Table 16, p. 50  
Desoxyn (methamphetamine) – **PA**  
Desyrel # (trazodone) – see Table 17, p. 51  
Detrol (tolterodine)  
Dexacidin (neomycin/polymyxin B/dexamethasone)  
Dexacine (neomycin/polymyxin B/dexamethasone)  
dexamethasone  
dexamethasone/neomycin  
Dexasporin (neomycin/polymyxin B/dexamethasone)  
dextbrompheniramine/pseudoephedrine – see Table 12, p. 46  
dexchlorpheniramine – see Table 12, p. 46  
Dexedrine # (dextroamphetamine)  
Dexferrum (iron dextran)  
dexmethylphenidate  
dextroamphetamine  
dextrose  
Dextrostat # (dextroamphetamine)  
D.H.E. 45 (dihydroergotamine mesylate)  
DHT (dihydrotachysterol)  
DiaBeta (glyburide) – **PA**; see Table 26, p. 60  
Diabinese # (chlorpropamide) – see Table 26, p. 60  
Diamox # (acetazolamide)  
Diastat (diazepam) – see Table 20, p. 54

diazepam – see Table 7, p. 41; see Table 20, p. 54  
diazoxide  
dichlorphenamide  
diclofenac – see Table 11, p. 45  
diclofenac/misoprostol – **PA < 60 years**; see Table 11, p. 45  
dicloxacillin  
dicyclomine  
didanosine  
Didronel (etidronate)  
dienestrol  
Differin (adapalene) – **PA > 25 years**; see Table 10, p. 44  
diflorasone – see Table 16, p. 50  
Diflucan # (fluconazole)  
diflunisal – see Table 11, p. 45  
Digitek (digoxin)  
digoxin  
dihydrocodeine/aspirin/cafeine  
dihydroergotamine  
dihydrotachysterol  
Dilacor # (diltiazem) – see Table 22, p. 56  
Dilantin (phenytoin) – see Table 20, p. 54  
Dilatrate-SR (isosorbide)  
Dilaudid # (hydromorphone) – **PA > 60 mg/day**; see Table 8, p. 42  
diltiazem – see Table 22, p. 56  
Diovan (valsartan) – **PA**; see Table 18, p. 52  
Diovan HCT (valsartan/hydrochlorothiazide) – **PA**; see Table 18, p. 52  
Dipentum (olsalazine)  
diphenhydramine \* – see Table 12, p. 46  
diphenhydramine/pseudoephedrine \* – see Table 12, p. 46  
diphenoxylate/atropine  
dipivefrin  
Diprolene (betamethasone) – **PA**; see Table 16, p. 50  
Diprolene AF # (augmented betamethasone) – see Table 16, p. 50  
dipyridamole  
dipyridamole/aspirin  
Diquinol (iodoquinol)  
dirithromycin  
Disalcid # (salsalate)  
disopyramide  
disulfiram

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## Alphabetic List (cont.)

Ditropan # (oxybutynin)  
Diuril # (chlorothiazide)  
divalproex – see Table 20, p. 54  
docetaxel  
docusate sodium \*  
dofetilide  
dolasetron – **PA > 15 units/month**; See Table 27, p. 61  
Dolobid # (diflunisal) – see Table 11, p. 45  
Dolophine # (methadone) – **PA > 120 mg/day**; see Table 8, p. 42  
Domeboro # (aluminum acetate)  
donepezil  
Doral (quazepam) – **PA**; see Table 15, p. 49  
dornase alpha  
Doryx (doxycycline)  
dorzolamide  
dorzolamide/timolol  
Dostinex (cabergoline)  
Dovonex (calcipotriene)  
doxazosin – see Table 19, p. 53  
doxepin – see Table 17, p. 51  
doxercalciferol  
doxorubicin  
doxycycline  
Drisdol # (ergocalciferol)  
dronabinol – **PA**  
droperidol  
Droxia (hydroxyurea)  
Drysol (aluminum chloride)  
DTIC-Dome # (dacarbazine)  
duloxetine – **PA**  
DuoNeb (albuterol/ipratropium) – see Table 23, p. 57  
Duphalac (lactulose)  
Duragesic (fentanyl transdermal system) – **PA**; see Table 8, p. 42  
Duramorph (morphine) – see Table 8, p. 42  
Duricef # (cefadroxil)  
dutasteride – **PA**  
Dyazide # (triamterene/hydrochlorothiazide)  
Dynabac (dirithromycin)  
Dynacin # (minocycline)  
Dynacirc (isradipine) – **PA**; see Table 22, p. 56  
Dynapen (dicloxacillin)  
dyphylline-GG (dyphylline/guaifenesin)  
dyphylline/guaifenesin

## E

echothiophate iodine  
econazole  
Econopred # (prednisolone)  
Edocrin (ethacrynic acid)  
Edex (alprostadiol) – **PA**; see Table 6, p. 40  
efalizumab – **PA**; see Table 5, p. 39  
efavirenz  
Effexor (venlafaxine) – **PA**; see Table 17, p. 51  
Effexor XR (venlafaxine extended-release) – **PA**; see Table 17, p. 51  
Efudex (fluorouracil)  
Elavil # (amitriptyline) – see Table 17, p. 51  
Eldepryl # (selegiline)  
electrolyte solution, pediatric \*  
Elestat (epinastine)  
eletriptan – **PA**; see Table 14, p. 48  
Elidel (pimecrolimus)  
Eligard (leuprolide) – **PA**; see Table 2, p. 36  
Elimite # (permethrin)  
Elitek (rasburicase)  
Elixophyllin-KI (theophylline/potassium iodide)  
Ellence (epirubicin)  
Elmiron (pentosan)  
Elocon (mometasone) – **PA**; see Table 16, p. 50  
Eloxatin (oxaliplatin)  
Emadine (emedastine)  
Embeline # (clobetasol) – see Table 16, p. 50  
Emcyt (estramustine)  
Emedastine  
Emend (aprepitant) – **PA > 3 units/14 days**  
Emgel # (erythromycin)  
EMLA (lidocaine/prilocaine)  
emtricitabine  
emtricitabine/tenofovir  
Emtriva (emtricitabine)  
E-Mycin # (erythromycin)  
enalapril – see Table 18, p. 52  
enalapril/felodipine – **PA**; see Table 18, p. 52; see Table 22, p. 56  
enalapril/hydrochlorothiazide – see Table 18, p. 52  
Enbrel (etanercept) – **PA**; see Table 5, p. 39  
Endocet (oxycodone/acetaminophen) – see Table 8, p. 42  
Endocodone (oxycodone) – **PA > 240 mg/day**; see Table 8, p. 42  
Endodan (oxycodone/aspirin) – see Table 8, p. 42

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**#** This is a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

**\*** The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

**°** Prior-authorization status depends on the drug’s formulation.

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## Alphabetic List (cont.)

Enduron # (methyclothiazide)  
Enduronyl (methyclothiazide/deserpidine)  
enfuvirtide – **PA**  
Engerix-B (hepatitis B, recombinant vaccine)  
enoxaparin  
Enpresse (levonorgestrel/ethinyl estradiol)  
entacapone  
entacapone/carbidopa/levodopa – **PA**  
Entocort (budesonide)  
Enulose (lactulose)  
Epifoam (hydrocortisone/pramoxine)  
Epifrin # (epinephrine)  
epinastine  
epinephrine  
Epipen (epinephrine)  
epirubicin  
Epitol (carbamazepine) – see Table 20, p. 54  
Epivir (lamivudine)  
eplerenone – **PA**  
epoetin alfa – **PA**; see Table 4, p. 38  
Epogen (epoetin alfa) – **PA**; see Table 4, p. 38  
epoprostenol  
eprosartan – **PA**; see Table 18, p. 52  
Epzicom (abacavir/lamivudine)  
Equagesic (meprobamate/aspirin)  
Equanil (meprobamate)  
Erbix (cetuximab)  
ergocalciferol  
ergoloid  
Ergomar (ergotamine)  
ergotamine  
ergotamine/caffeine  
Ertaczo (sertaconazole) – **PA**  
Eryped # (erythromycin)  
Ery-tab (erythromycin)  
Erythrocin (erythromycin)  
erythromycin  
erythromycin/sulfisoxazole  
escitalopram – **PA**; see Table 17, p. 51  
Esclim # (estradiol)  
Esgic # (butalbital/acetaminophen/caffeine)  
Eskalith # (lithium)  
esmolol – see Table 21, p. 55  
esomeprazole – **PA**; see Table 3, p. 37  
estazolam – **PA > 10 units/month**; see Table 15, p. 49  
Estinyl (ethinyl estradiol)  
Estrace # (estradiol)

Estraderm (estradiol)  
estradiol °  
estradiol/medroxyprogesterone  
estradiol/norethindrone  
estramustine  
Estrasorb (estradiol) – **PA**  
Estratab # (estrogens, esterified)  
Estring (estradiol)  
estriol  
EstroGel (estradiol) – **PA**  
estrogens, conjugated  
estrogens, conjugated/medroxyprogesterone  
estrogens, esterified  
estrogens, esterified/methyltestosterone  
estropiate  
Estrostep Fe (ethinyl estradiol/norethindrone)  
Estrostep 21 (ethinyl estradiol/norethindrone)  
etanercept – **PA**; see Table 5, p. 39  
ethacrynic acid  
ethambutol  
Ethezyme (papain/urea)  
ethinyl estradiol  
ethinyl estradiol/desogestrel  
ethinyl estradiol/drospirenone  
ethinyl estradiol/ethynodiol  
ethinyl estradiol/levonorgestrel  
ethinyl estradiol/norelgestromin  
ethinyl estradiol/norethindrone  
ethinyl estradiol/norgestimate  
ethinyl estradiol/norgestrel  
Ethmazine (moricizine)  
ethosuximide – see Table 20, p. 54  
ethotoin – see Table 20, p. 54  
etidronate  
etodolac – see Table 11, p. 45  
etonogestrel/ethinyl estradiol  
etoposide  
etretinate – see Table 10, p. 44  
Eulexin # (flutamide)  
Eurax (crotamiton)  
Evista (raloxifene)  
Evoxac (cevimeline)  
Exelderm (sulconazole)  
Exelon (rivastigmine)  
exemestane  
ezetimibe – **PA**  
ezetimibe/simvastatin – **PA**; see Table 13, p. 47

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## Alphabetic List (cont.)

### E

- Fabrazyme (agalsidase) – **PA**  
Factive (gemifloxacin)  
factor IX complex  
factor IX, human  
factor IX, recombinant  
famciclovir  
famotidine \* – see Table 3, p. 37  
Famvir (famciclovir)  
Farbital (butalbital/aspirin/caffeine)  
Fareston (toremifene)  
Faslodex (fulvestrant) – **PA**  
fat emulsion, intravenous  
Fazaclo (clozapine, orally disintegrating tablet) – **PA**  
Feiba VH Immuno (anti-inhibitor coagulant complex)  
felbamate – see Table 20, p. 54  
Felbatol (felbamate) – see Table 20, p. 54  
Feldene # (piroxicam) – see Table 11, p. 45  
felodipine – **PA**; see Table 22, p. 56  
Femara (letrozole)  
Femhrt (ethinyl estradiol/norethindrone)  
Femring (estradiol) – **PA**  
fenofibrate  
fenoprofen – see Table 11, p. 45  
fentanyl, injection – see Table 8, p. 42  
fentanyl transdermal system – **PA**; see Table 8, p. 42  
fentanyl, transmucosal system – **PA**; see Table 8, p. 42  
Ferrelecit (sodium ferric gluconate complex)  
ferrous fumarate \*  
ferrous gluconate \*  
ferrous sulfate \*  
fexofenadine – **PA**; see Table 12, p. 46  
fexofenadine/pseudoephedrine – **PA**; see Table 12, p. 46  
filgrastim – **PA**; see Table 4, p. 38  
finasteride – **PA**  
Finevin (azelaic acid)  
Fioricet # (butalbital/acetaminophen/caffeine)  
Fioricet/codeine # (butalbital/acetaminophen/codeine/caffeine)  
Fiorinal # (butalbital/aspirin/caffeine)  
Fiorinal/codeine # (butalbital/codeine/aspirin/caffeine)  
Fiorep (butalbital/acetaminophen/caffeine)  
Fiortal (butalbital/aspirin/caffeine)  
Flagyl # (metronidazole)  
Flarex # (fluorometholone)  
flavoxate  
flecainide  
Flexeril # (cyclobenzaprine) – see Table 7, p. 41  
Flexoject (orphenadrine) – see Table 7, p. 41  
Flexon (orphenadrine) – see Table 7, p. 41  
Flolan (epoprostenol)  
Flomax (tamsulosin) – **PA**; see Table 19, p. 53  
Flonase (fluticasone), nasal spray – **PA > 1 inhaler/month**; see Table 25, p. 59  
Florinef # (fludrocortisone)  
flouormetholone  
Flovent (fluticasone) – see Table 23, p. 57  
Floxin (ofloxacin)  
fluconazole  
flucytosine  
fludrocortisone  
Flumadine # (rimantadine)  
Flumist (influenza virus vaccine live, intranasal) – **PA**  
flunisolide, ° inhaler – see Table 23, p. 57  
flunisolide, ° nasal spray – **PA > 1 inhaler/month**; see Table 25, p. 59  
fluocinolone ° – see Table 16, p. 50  
fluocinonide – see Table 16, p. 50  
fluorides  
Fluoritab (sodium fluoride)  
fluorometholone  
fluorometholone/sulfacetamide  
Fluor-op (fluorometholone)  
Fluoroplex (fluorouracil)  
fluorouracil  
fluoxetine ° – see Table 17, p. 51  
fluoxetine/olanzapine – **PA**; see Table 17, p. 51; see Table 24, p. 58  
fluoxymesterone  
fluphenazine  
flurandrenolide ° – see Table 16, p. 50  
flurazepam – **PA > 10 units/month**; see Table 15, p. 49  
flurbiprofen – see Table 11, p. 45  
fluroxamine  
flutamide  
fluticasone, inhalation – see Table 23, p. 57  
fluticasone, nasal spray – **PA > 1 inhaler/month**; see Table 25, p. 59

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## Alphabetic List (cont.)

fluticasone, topical – see Table 16, p. 50  
fluticasone/salmeterol – see Table 23, p. 57  
fluvastatin – **PA > 30 units/month**; see Table 13, p. 47  
fluvastatin extended-release – **PA > 30 units/month**; see Table 13, p. 47  
Fluvirin (influenza vaccine)  
fluvoxamine – see Table 17, p. 51  
FML # (fluorometholone)  
FML-S (fluorometholone/sulfacetamide)  
Focalin (dexamethylphenidate)  
folic acid \*  
folic acid/multivitamin– **PA**  
folic acid/multivitamin/saw palmetto– **PA**  
Foltrate (cyanocobalamin/folic acid) – **PA**  
fondaparinux – **PA > 11 doses/Rx**  
Foradil (formoterol) – see Table 23, p. 57  
formaldehyde  
Formaldehyde-10 (formaldehyde)  
formoterol – see Table 23, p. 57  
Fortamet (metformin extended-release) – **PA**; see Table 26, p. 60  
Fortaz (ceftazidime)  
Forteo (teriparatide) – **PA**  
Fortovase (saquinavir)  
Fosamax (alendronate)  
fosamprenavir  
foscarnet  
Foscavir (foscarnet)  
fosfomycin  
fosinopril – see Table 18, p. 52  
Fragmin (dalteparin)  
Frova (frovatriptan) – **PA**; see Table 14, p. 48  
frovatriptan – **PA**; see Table 14, p. 48  
fulvestrant – **PA**  
Fulvicin # (griseofluvin)  
Fungizone (amphotericin B)  
Furacin (nitrofurazone)  
Furadantin (nitrofurantoin)  
furazolidone  
furosemide  
Furoxone (furazolidone)  
Fuzeon (enfuvirtide) – **PA**

## G

gabapentin – **PA > 18 years**; see Table 20, p. 54

gabapentin powder – **PA > 18 years**; see Table 20, p. 54  
Gabitril (tiagabine) – **PA > 18 years**; see Table 20, p. 54  
galantamine  
Gamimune N (immune globulin IV, human) – **PA**; see Table 1, p. 35  
Gammagard S/D (immune globulin IV, human) – **PA**; see Table 1, p. 35  
Gammar-P IV (immune globulin IV, human) – **PA**; see Table 1, p. 35  
Gamulin Rh (Rho (D) immune globulin IM) – see Table 1, p. 35  
Gamunex (immune globulin IV, human) – **PA**; see Table 1, p. 35  
ganciclovir  
Gantrisin (sulfisoxazole)  
Gastrocrom (cromolyn)  
gatifloxacin  
gefitinib  
gelatin  
gemcitabine  
gemfibrozil  
gemifloxacin  
Gemzar (gemcitabine)  
Gengraf (cyclosporine)  
Genora (ethinyl estradiol/norethindrone)  
Genotropin (somatropin) – **PA**; see Table 9, p. 43  
Gentacidin (gentamicin)  
Gentak (gentamicin)  
gentamicin  
Geocillin (carbenicillin)  
Geodon (ziprasidone) – see Table 24, p. 58  
Geodon (ziprasidone), injection  
glatiramer  
Gleevec (imatinib)  
glimepiride – **PA**; see Table 26, p. 60  
glipizide – see Table 26, p. 60  
glipizide extended-release – see Table 26, p. 60  
glipizide/metformin – **PA**; see Table 26, p. 60  
glucagon  
gluconic acid/citric acid  
Glucophage # (metformin) – see Table 26, p. 60  
Glucophage XR # (metformin extended-release) – see Table 26, p. 60  
Glucotrol # (glipizide) – see Table 26, p. 60  
Glucotrol XL # (glipizide extended-release) – see Table 26, p. 60

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## Alphabetic List (cont.)

Glucovance (glyburide/metformin) – **PA**;  
see Table 26, p. 60  
glyburide ° – see Table 26, p. 60  
glyburide/metformin – **PA**; see Table 26, p. 60  
glyburide, micronized – see Table 26, p. 60  
glycerin  
glycopyrrolate  
Glynase # (glyburide) – see Table 26, p. 60  
Glyset (miglitol) – **PA**; see Table 26, p. 60  
gold sodium thiomalate  
GoLYTELY # (polyethylene glycol-electrolyte solution)  
goserelin – **PA**; see Table 2, p. 36  
granisetron – **PA > 15 units/month, liquid formulation; PA > 30mL/month**; See Table 27, p. 61  
Granul-derm (castor oil/peru balsam/trypsin)  
Granulex # (castor oil/peru balsam/trypsin)  
Grifulvin # (griseofulvin)  
griseofulvin  
Gris-Peg # (griseofulvin)  
guaifenesin/dyphylline  
guanabenz  
guanfacine  
Gynazole-1 (butoconazole)  
Gynodiol (estradiol)

## H

halcinonide – **PA**; see Table 16, p. 50  
Halcion # (triazolam) – **PA > 10 units/month**;  
see Table 15, p. 49  
Haldol # (haloperidol)  
halobetasol – **PA**; see Table 16, p. 50  
Halog (halcinonide) – **PA**; see Table 16, p. 50  
Halog-E (halcinonide) – **PA**; see Table 16, p. 50  
haloperidol  
Haponal (belladonna/phenobarbital)  
Havrix (hepatitis A vaccine, inactivated)  
HBIG (hepatitis B immune globulin, human) –  
see Table 1, p. 35  
Hectorol (doxercalciferol)  
Helidac (bismuth subsalicylate/tetracycline/  
metronidazole)  
Helixate (antithemophilic factor, recombinant)  
Hemofil-M (antithemophilic factor, recombinant)  
Hep-Lock # (heparin)  
heparin

heparin lock flush  
hepatitis A vaccine, inactivated  
hepatitis A vaccine inactivated/hepatitis B,  
recombinant vaccine  
hepatitis B immune globulin, human – see Table 1,  
p. 35  
hepatitis B, recombinant vaccine  
Hepsera (adefovir)  
Herceptin (trastuzumab)  
hexachlorophene  
Hiprex (methenamine)  
Hivid (zalcitabine)  
homatropine  
Humate-P (antihemophilic factor, human)  
Humatin # (paromomycin)  
Humatrope (somatropin) – **PA**; see Table 9, p. 43  
Humira (adalimumab) – **PA**; see Table 5, p. 39  
Hyalgan (hyaluronate) – **PA**  
hyaluronan – **PA**  
hyaluronate – **PA**  
hydralazine  
hydralazine/hydrochlorothiazide  
Hydra-zide # (hydralazine/hydrochlorothiazide)  
Hydrea # (hydroxyurea)  
Hydrocet # (hydrocodone/acetaminophen) – see  
Table 8, p. 42  
hydrochlorothiazide  
hydrocodone/acetaminophen ° – see Table 8, p. 42  
hydrocodone/ibuprofen ° – see Table 8, p. 42  
hydrocortisone  
hydrocortisone, topical ° – see Table 16, p. 50  
hydrocortisone/lidocaine  
hydrogen peroxide \*  
hydromorphone – **PA > 60 mg/day**; see Table 8,  
p. 42  
hydromorphone extended-release capsules – **PA**;  
see Table 8, page 42  
hydromorphone powder – **PA**; see Table 8, p. 42  
hydroxychloroquine  
hydroxycobalamin  
hydroxyprogesterone  
hydroxyurea  
hydroxyzine – see Table 12, p. 46  
hylan polymers – **PA**  
Hylutin (hydroxyprogesterone)  
hyoscyamine  
hyoscyamine/phenobarbital  
Hyosol/SL (hyoscyamine, sublingual)

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## Alphabetic List (cont.)

Hyospaz (hyoscyamine)  
HyperHep (hepatitis B immune globulin, human) – see Table 1, p. 35  
HypRho-D (Rho(D) immune globulin IM) – see Table 1, p. 35  
HypRho-D Mini-Dose (Rho(D) immune globulin IM micro-dose) – see Table 1, p. 35  
Hytakerol (dihydrotachysterol)  
Hytone # (hydrocortisone) – see Table 16, p. 50  
Hytrin # (terazosin) – see Table 19, p. 53  
Hyzaar (losartan/hydrochlorothiazide) – **PA**; see Table 18, p. 52

## I

ibritumomab – **PA**  
ibuprofen \* – see Table 11, p. 45  
imatinib  
Imdur # (isosorbide)  
imiglucerase  
imipenem/cilastatin  
imipramine – see Table 17, p. 51  
imiquimod  
Imitrex (sumatriptan), injection – **PA > 2 units (4 injections/month)**; see Table 14, p. 48  
Imitrex (sumatriptan), nasal spray – **PA**; see Table 14, p. 48  
Imitrex (sumatriptan), tablet – **PA**; see Table 14, p. 48  
immune globulin IV, human – **PA**; see Table 1, p. 35  
Imogam Rabies-HT (rabies immune globulin IM, human) – see Table 1, p. 35  
Imovax (rabies vaccine)  
Imuran # (azathioprine)  
Inapsine # (droperidol)  
indapamide  
Inderal # (propranolol) – see Table 21, p. 55  
Inderide # (propranolol/hydrochlorothiazide) – see Table 21, p. 55  
indinavir  
Indocin # (indomethacin) – see Table 11, p. 45  
indomethacin – see Table 11, p. 45  
Infed (iron dextran)  
Infergen (interferon alfacon-1) – see Table 5, p. 39  
Inflamase # (prednisolone/sodium phosphate)  
infliximab – **PA**; see Table 5, p. 39

influenza vaccine  
influenza virus vaccine live, intranasal – **PA**  
Infumorph (morphine) – see Table 8, p. 42  
InnoPran XL (propranolol extended-release) – **PA**; see Table 21, p. 55  
Inspira (eplerenone) – **PA**  
insulin, prefilled syringes – **PA**  
insulins \*  
Intal # (cromolyn), inhalation solution – see Table 23, p. 57  
Intal (cromolyn), inhaler – see Table 23, p. 57  
interferon alfa-2a – see Table 5, p. 39  
interferon alfa-2b – see Table 5, p. 39  
interferon alfa-2b/ribavirin – **PA**; see Table 5, p. 39  
interferon alfacon-1 – see Table 5, p. 39  
interferon alfa-n3, human leukocyte derived – see Table 5, p. 39  
interferon beta-1a – see Table 5, p. 39  
interferon beta-1b – see Table 5, p. 39  
interferon gamma-1b – see Table 5, p. 39  
Intron A (interferon alfa-2b) – see Table 5, p. 39  
Inversine (mecamylamine)  
Invirase (saquinavir)  
iodine \*  
iodoquinol/hydrocortisone  
lopidine (apraclonidine)  
ipratropium, inhalation solution – see Table 23, p. 57  
ipratropium, inhaler – see Table 23, p. 57  
ipratropium, nasal spray  
irbesartan – **PA**; see Table 18, p. 52  
irbesartan/hydrochlorothiazide – **PA**; see Table 18, p. 52  
Iressa (gefitinib)  
irinotecan  
iron dextran  
iron sucrose  
Ismo # (isosorbide)  
isoetharine – see Table 23, p. 56  
isoniazid  
isopropyl alcohol \*  
Isoptin # (verapamil) – see Table 22, p. 56  
Isordil # (isosorbide)  
isosorbide  
isotretinoin – see Table 10, p. 44  
isradipine – **PA**; see Table 22, p. 56  
itraconazole  
Iveegam EN (immune globulin IV, human) – **PA**; see Table 1, p. 35

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## Alphabetic List (cont.)

ivermectin

### J

Japanese encephalitis virus vaccine

Jenest-28 (ethinyl estradiol/norethindrone)

JE-Vax (Japanese encephalitis virus vaccine)

### K

Kadian (morphine sustained release) –

**PA > 360 mg/day**; see Table 8, p. 42

Kaletra (lopinavir/ritonavir)

Kaochlor (potassium chloride)

kaolin/pectin \*

Kaon-Cl (potassium chloride)

Kariva (ethinyl estradiol/desogestrel)

Kayexalate # (sodium polystyrene sulfonate)

K-Dur # (potassium chloride)

Keflex # (cephalexin)

Keftab (cephalexin)

Kefurox # (cefuroxime)

Kemadrin (procyclidine)

Kenalog # (triamcinolone) – see Table 16, p. 50

Keppra (levetiracetam) – **PA**; see Table 20, p. 54

Kerlone # (betaxolol) – see Table 21, p. 55

ketamine – **PA**

Ketek (telithromycin)

ketoconazole

ketoprofen \* – see Table 11, p. 45

ketorolac – **PA > 20 units/month**; see Table 11, p. 45

ketotifen

Kineret (anakinra) – **PA**; see Table 5, p. 39

Kionex # (sodium polystyrene sulfonate)

Klaron (sulfacetamide)

Klonopin # (clonazepam) – see Table 20, p. 54

Klonopin Wafers (clonazepam, orally disintegrating tablets) – **PA**; see Table 20, p. 54

K-Lor # (potassium chloride)

Klor-Con # (potassium chloride)

Klotrix (potassium chloride)

K-Lyte (potassium bicarbonate)

K-Lyte/Cl # (potassium chloride/potassium bicarbonate)

Koate-DVI (antihemophilic factor, human)

Kogenate (antihemophilic factor, recombinant)

Konyne 80 (factor IX complex)

Kovia (papain/urea)

K-Phos M.F. (potassium phosphate/sodium phosphate)

K-Phos Neutral (potassium phosphate/dibasic sodium phosphate/monobasic sodium phosphate)

K-Phos No. 2 (potassium phosphate/sodium phosphate/phosphorus)

K-Phos Original (potassium phosphate)

Kristalose (lactulose)

K-Tab (potassium chloride)

Kutapressin (liver derivative complex)

K-Vescent Potassium Chloride (potassium chloride)

Kytril (granisetron) – **PA > 15 units/month, liquid formulation; PA > 30 mL/month**; See Table 27, p. 61

### L

labetalol – see Table 21, p. 55

Lac-Hydrin (ammonium lactate) – **PA**

LAClotion (ammonium lactate)

lactic acid #

lactic acid/vitamin E

Lactinol (lactic acid)

Lactinol-E (lactic acid/vitamin E)

lactose

lactulose

Lamictal (lamotrigine) – see Table 20, p. 54

Lamisil (terbinafine)

lamivudine

lamivudine/zidovudine

lamotrigine – see Table 20, p. 54

lanolin \*

Lanoxicaps (digoxin)

Lanoxin # (digoxin)

lansoprazole – **PA > 16 years (except suspension for LTC members)**; see Table 3, p. 37

lansoprazole IV – **PA**; see Table 3, p. 37

lansoprazole, orally disintegrating tablet – **PA > 16 years**; see Table 3, p. 37

lansoprazole/amoxicillin/clarithromycin

lansoprazole/naproxen – **PA**; see Table 11, p. 45

Lantus (insulin glargine)

Lariam (mefloquine)

Larodopa (levodopa)

laronidase – **PA**

Lasix # (furosemide)

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## Alphabetic List (cont.)

latanoprost  
Lazer Formalyde (formaldehyde)  
L-Carnitine (levocarnitine)  
leflunomide  
lepirudin – **PA**  
Lescol (fluvastatin) – **PA > 30 units/month**; see Table 13, p. 47  
Lescol XL (fluvastatin extended-release) **PA > 30 units/month**; see Table 13, p. 47  
letrozole  
leucovorin  
Leukeran (chlorambucil)  
Leukine (sargramostim) – **PA**; see Table 4, p. 38  
leuprolide – **PA**; see Table 2, p. 36  
levalbuterol – **PA**; see Table 23, p. 57  
Levaquin (levofloxacin)  
Levatol (penbutolol) – **PA**; see Table 21, p. 55  
Levbid (hyoscyamine)  
levetiracetam – **PA**; see Table 20, p. 54  
Levitra (vardenafil) – **PA**; see Table 6, p. 39  
Levlen # (ethinyl estradiol/levonorgestrel)  
Levite (ethinyl estradiol/levonorgestrel)  
Levo-Dromoran # (levorphanol) – **PA > 32 mg/day**; see Table 8, p. 42  
levocabastine  
levocarnitine  
levobunolol  
levodopa  
levofloxacin  
levonorgestrel  
levonorgestrel IUD  
Levora # (ethinyl estradiol/levonorgestrel)  
levorphanol – **PA > 32 mg/day**; see Table 8, p. 42  
levorphanol powder – **PA**; see Table 8, p. 42  
Levothroid (levothyroxine)  
levothyroxine  
Levoxyl # (levothyroxine)  
Levsin (hyoscyamine)  
Levsin PB (hyoscyamine/phenobarbital)  
Levsinex Timecaps # (hyoscyamine)  
Lexapro (escitalopram) – **PA**; see Table 17, p. 51  
Lexiva (fosamprenavir)  
Lexxel (enalapril/felodipine) – **PA**; see Table 18, p. 52; see Table 22, p. 56  
Lida-Mantle-HC Cream (hydrocortisone/lidocaine)  
Lidex # (fluocinonide) – see Table 16, p. 50  
lidocaine  
lidocaine patch – **PA**  
lidocaine/prilocaine  
Lidoderm (lidocaine) – **PA**  
lindane  
linezolid  
Lioresal # (baclofen) – see Table 7, p. 41  
Lioresal Intrathecal (baclofen) – **PA**; see Table 7, p. 41  
liothyronine  
liothyronine/thyroxine  
Liotrix (liothyronine/thyroxine)  
Lipitor (atorvastatin) – **PA > 30 units/month**; see Table 13, p. 47  
Liposyn # (fat emulsion, intravenous)  
Lipram (amylase/lipase/protease)  
lisinopril – see Table 18, p. 52  
lisinopril/hydrochlorothiazide – see Table 18, p. 52  
lithium  
Lithobid # (lithium)  
Lithostat (acetohydroxamic acid)  
liver derivative complex  
Livostin (levocabastine)  
Lo/Ovral # (ethinyl estradiol/norgestrel)  
LoCHOLEST # (cholestyramine)  
Locoid (hydrocortisone) – **PA**; see Table 16, p. 50  
Iodoxamide  
Lodine # (etodolac) – see Table 11, p. 45  
Lodosyn (carbidopa)  
Loestrin # (ethinyl estradiol/norethindrone)  
Lomotil # (diphenoxylate/atropine)  
lomustine  
Lonox # (diphenoxylate/atropine)  
loperamide \*  
Lopid # (gemfibrozil)  
lopinavir/ritonavir  
Lopressor # (metoprolol) – see Table 21, p. 55  
Lopressor HCT # (metoprolol/hydrochlorothiazide) – see Table 21, p. 55  
Loprox # (ciclopirox)  
Lorabid (loracarbef)  
loracarbef  
loratadine – see Table 12, p. 46  
lorazepam

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## Alphabetic List (cont.)

Lorcet # (hydrocodone/acetaminophen) – see Table 8, p. 42  
Lortab # (hydrocodone/acetaminophen) – see Table 8, p. 42  
losartan – **PA**; see Table 18, p. 52  
losartan/hydrochlorothiazide – **PA**; see Table 18, p. 52  
Lotemax (loteprednol)  
Lotensin # (benazepril); see Table 18, p. 52  
loteprednol  
Lotrel (amlodipine/benazepril) – **PA**; see Table 18, p. 52; see Table 22, p. 56  
Lotrimin # (clotrimazole)  
Lotrisone # (clotrimazole/betamethasone)  
Lotronex (alosetron) – **PA**  
lovastatin – **PA > 30 units/month**; see Table 13, p. 47  
lovastatin extended-release – **PA**; see Table 13, p. 47  
lovastatin/niacin – **PA**; see Table 13, p. 47  
Lovenox (enoxaparin)  
Low-Ogestrel # (ethinyl estradiol/norgestrel)  
loxapine  
Loxitane # (loxapine)  
Lozol # (indapamide)  
Lufyllin-GG (dyphylline/guaifenesin)  
Lumigan (bimatoprost)  
Lunelle (estradiol/medroxyprogesterone)  
Lupron (leuprolide) – **PA**; see Table 2, p. 36  
Luride # (sodium fluoride)  
Luvox # (fluvoxamine) – see Table 17, p. 51  
Luxiq (betamethasone) – **PA**; see Table 16, p. 50

## **M**

Macrobid (nitrofurantoin)  
Macrochantin # (nitrofurantoin)  
mafenide  
magaldrate \*  
magnesium carbonate/citric acid/gluconolactone  
magnesium citrate \*  
magnesium gluconate \*  
magnesium hydroxide \*  
magnesium trisilicate \*  
Malarone (atovaquone/proguanil)  
Mandelamine (methenamine)  
maprotiline – see Table 17, p. 51

Marcaine # (bupivacaine)  
Marinol (dronabinol) – **PA**  
Marten-tab # (butalbital/acetaminophen)  
Matulane (procarbazine)  
Mavik (trandolapril) – **PA**; see Table 18, p. 52  
Maxair (pirbuterol) – **PA**; see Table 23, p. 57  
Maxalt (rizatriptan) – **PA**; see Table 14, p. 48  
Maxalt-MLT (rizatriptan, orally disintegrating tablet) – **PA**; Table 14, p. 48  
Maxidex (dexamethasone)  
Maxidone (hydrocodone/acetaminophen) – **PA**; see Table 8, p. 42  
Maxipime (cefepime)  
Maxitrol # (neomycin/polymyxin B/dexamethasone)  
Maxzide # (triamterene/hydrochlorothiazide)  
Mebaral (mephobarbital)  
mebendazole  
mecamylamine  
mechlorethamine  
meclizine \*  
meclofenamate – see Table 11, p. 45  
Medrol # (methylprednisolone)  
medroxyprogesterone  
medroxyprogesterone/estrogen conjugated  
mefenamic acid – **PA**; see Table 11, p. 45  
mefloquine  
Mefoxin # (cefoxitin)  
Megace # (megestrol)  
megestrol  
Mellaril # (thioridazine)  
meloxicam – **PA < 60 years**; see Table 11, p. 45  
melphalan  
memantine  
Menest (estrogens, esterified)  
meningococcal polysaccharide vaccine  
Menomune-A/C/Y/W-135 (meningococcal polysaccharide vaccine)  
Menostar (estradiol) – **PA**  
Mentax (butenafine)  
mepenzolate  
meperidine – **PA > 750 mg/day**; see Table 8, p. 42  
mephobarbital  
Mephyton (phytonadione)  
meprobamate  
meprobamate/aspirin  
Mepron (atovaquone)  
mercaptopurine

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## Alphabetic List (cont.)

meropenem  
Merrem (meropenem)  
mesalamine  
mesna  
Mesnex (mesna)  
mesoridazine  
Mestinon # (pyridostigmine)  
Metadate # (methylphenidate)  
Metaglip (metformin/glipizide) – **PA**;  
    see Table 26, p. 60  
metaproterenol, inhalation solution – see  
    Table 23, p. 57  
metaproterenol, inhaler – **PA**; see Table 23,  
    p. 57  
metaxalone – see Table 7, p. 41  
metformin – see Table 26, p. 60  
metformin extended-release ° – see Table 26,  
    p. 60  
metformin solution – see Table 26, p. 60  
metformin/rosiglitazone – **PA**; see Table 26,  
    p. 60  
methadone – **PA > 120 mg/day**; see Table 8,  
    p. 42  
methadone powder – **PA**; See Table 8, p. 42  
Methadose # (methadone) – **PA > 120 mg/day**;  
    see Table 8, p. 42  
methamphetamine – **PA**  
methazolamide  
methenamine  
methenamine/benzoic acid/atropine/  
    hyoscyamine/methylene blue  
methenamine/benzoic acid/atropine/  
    hyoscyamine/phenyl salicylate/methylene blue  
methenamine/benzoic acid/atropine/  
    hyoscyamine/saldol/methylene blue  
methenamine/hyoscyamine/methylene blue  
methenamine/sodium acid phosphate  
Methergine (methylergonovine)  
methimazole  
Methitest (methyltestosterone)  
methocarbamol – see Table 7, p. 41  
methotrexate  
methoxsalen  
methscopolamine  
methsuximide – see Table 20, p. 54  
methyclothiazide  
methyclothiazide/deserpidine  
methyldopa  
methyldopa/hydrochlorothiazide  
methylergonovine  
Methylin # (methylphenidate)  
methylphenidate  
methylprednisolone  
methyltestosterone  
methysergide  
metipranolol  
metoclopramide  
metolazone  
metoprolol – see Table 21, p. 55  
metoprolol /hydrochlorothiazide – see Table 21,  
    p. 55  
MetroCream # (metronidazole)  
Metrogel (metronidazole)  
Metro lotion (metronidazole)  
metronidazole  
metyrosine  
Mevacor (lovastatin) – **PA**; see Table 13, p. 47  
mexiletine  
Mexitol # (mexiletine)  
Miacalcin # (calcitonin, salmon)  
Micanol (anthralin)  
Micardis (telmisartan) – **PA**; see Table 18, p. 52  
miconazole \*  
MICRhoGAM (Rho(D) immune globulin IM micro-  
    dose) – see Table 1, p. 35  
Microgestin Fe # (ethinyl estradiol/  
    norethindrone)  
Micro-K # (potassium chloride)  
Micronase # (glyburide) – see Table 26, p. 60  
Micronor (norethindrone)  
Microzide # (hydrochlorothiazide)  
Midamor # (amiloride)  
midazolam  
midodrine  
miglitol – **PA**; see Table 26, p. 60  
miglustat  
Migranal (dihydroergotamine)  
milrinone  
mineral oil \*  
Mini-Gamulin Rh (Rho(D) immune globulin IM micro-  
    dose) – see Table 1, p. 35  
Minitran # (nitroglycerin)  
Minizide (prazosin/polythiazide) – see Table 19,  
    p. 53  
Minocin # (minocycline)  
minocycline

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## Alphabetic List (cont.)

minoxidil  
Mintezol (thiabendazole)  
Miralax # (polyethylene glycol)  
Mirapex (pramipexole)  
Mircette # (ethinyl estradiol/desogestrel)  
Mirena (levonorgestrel IUD)  
mirtazapine – see Table 17, p. 51  
mirtazapine, orally disintegrating tablet – **PA**;  
see Table 17, p. 51  
misoprostol  
mitomycin  
mitoxantrone  
Moban (molindrone)  
Mobic (meloxicam) – **PA < 60 years**; see  
Table 11, p. 45  
modafinil – **PA**  
Modicon # (ethinyl estradiol/norethindrone)  
Moduretic # (amiloride/hydrochlorothiazide)  
moexipril – see Table 18, p. 52  
moexipril/hydrochlorothiazide – **PA**; see  
Table 18, p. 52  
Molindone  
mometasone,<sup>o</sup> topical – see Table 16, p. 50  
mometasone, nasal spray – **PA > 1**  
**inhaler/month**; see Table 25, p. 59  
Monarc-M (antihemophilic factor, human)  
Monoclade-P (antihemophilic factor, human)  
Monodox # (doxycycline)  
Monoket # (isosorbide)  
Mononine (factor IX, human)  
Monopril # (fosinopril) – see Table 18, p. 52  
montelukast – **PA > 16 years**  
Monurol (fosfomycin)  
moricizine  
morphine controlled release – **PA > 360**  
**mg/day**; see Table 8, p. 42  
morphine extended-release – **PA**; see Table 8,  
p. 42  
morphine immediate release – **PA > 360**  
**mg/day**; see Table 8, p. 42  
morphine injection – see Table 8, p. 42  
morphine powder – **PA**  
morphine sustained release – **PA > 360**  
**mg/day**; see Table 8, p. 42  
morphine suppositories – see Table 8, p. 42  
Motofen (atropine/difenoxin)  
Motrin # (ibuprofen \*) – see Table 11, p. 45  
moxifloxacin

MSIR (morphine) – **PA > 360 mg/day**; see Table 8,  
p. 42  
MS/L (morphine) – **PA > 360 mg/day**; see Table 8,  
p. 42  
MS Contin # (morphine) – **PA > 360 mg/day**; see  
Table 8, p. 42  
MS/S (morphine) – see Table 8, p. 42  
Mucomyst # (acetylcysteine)  
Mucomyst-10 (acetylcysteine)  
multivitamins \*  
multivitamins/minerals \*  
mupirocin  
Murocoll-2 (scopolamine/phenylephrine)  
Muse (alprostadil) – **PA**; see Table 6, p. 40  
Mustargen (mechlorethamine)  
Myambutol # (ethambutol)  
Mycobutin (rifabutin)  
Mycogen (nystatin/triamcinolone)  
Mycolog II # (nystatin/triamcinolone)  
mycophenolate  
Mycostatin # (nystatin)  
Mydrin (phenylephrine)  
Mydracil # (tropicamide)  
Myfortic (mycophenolate)  
Myobloc (botulinum toxin type B) – **PA**  
Mysoline # (primidone) – see Table 20, p. 54

## N

Nabi-HB (hepatitis B immune globulin, human) – see  
Table 1, p. 35  
nabumetone – see Table 11, p. 45  
nadolol – see Table 21, p. 55  
nadolol/bendroflumethiazide – see Table 21, p. 55  
nafarelin – **PA**; see Table 2, p. 36  
nafcillin  
naftifine  
Naftin (naftifine)  
nalbuphine  
Nalfon # (fenoprofen) – see Table 11, p. 45  
nalidixic acid  
Nallpen (nafcillin)  
naloxone  
naltrexone  
Namenda (memantine)  
nandrolone  
naphazoline  
Naprosyn # (naproxen \*) – see Table 11, p. 45

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## Alphabetic List (cont.)

naproxen \* – see Table 11, p. 45  
naproxen/lansoprazole – **PA**; see Table 11, p. 45  
Naqua (trichlormethiazide)  
naratriptan – **PA**; see Table 14, p. 48  
Nardil (phenelzine) – see Table 17, p. 51  
Nasacort (triamcinolone nasal spray) – **PA > 1 inhaler/month**; see Table 25, p. 59  
Nasacort AQ (triamcinolone nasal spray) – **PA > 1 inhaler/month**; see Table 25, p. 59  
Nasalide # (flunisolide nasal spray) – **PA > 1 inhaler/month**; see Table 25, p. 59  
Nasarel (flunisolide nasal spray) – **PA > 1 inhaler/month**; see Table 25, p. 59  
Nascobal (cyanocobalamin) – **PA**  
Nasonex (mometasone nasal spray) – **PA > 1 inhaler/month**; see Table 25, p. 59  
nateglinide – **PA**; see Table 26, p. 60  
Navane # (thiothixene)  
Navelbine (vinorelbine)  
Nebcin # (tobramycin)  
Nebupent (pentamidine)  
Necon # (ethinyl estradiol/norethindrone)  
nedocromil, inhaler – see Table 23, p. 57  
nedocromil ophthalmic  
nefazodone – see Table 17, p. 51  
NegGram # (nalidixic acid)  
nelfinavir  
Nelova # (ethinyl estradiol/norethindrone)  
Nembutal # (pentobarbital)  
Neo-Decadron (dexamethasone/neomycin)  
neomycin \*  
neomycin/polymyxin B/dexamethasone  
neomycin/polyxmyxin B/gramicidin  
neomycin/polymyxin B/hydrocortisone  
neomycin/polymyxin B/prednisolone  
Neoral (cyclosporine)  
Neosar # (cyclophosphamide)  
Neosporin Ophthalmic Solution #  
(neomycin/polymyxin B/gramicidin)  
neostigmine  
Neptazane # (methazolamide)  
Neulasta (pegfilgrastim) – **PA**; see Table 4, p. 38  
Neumega (oprelvekin) – **PA**; see Table 4, p. 38  
Neupogen (filgrastim) – **PA**; see Table 4, p. 38  
Neurontin # (gabapentin) – **PA > 18 years**; see Table 20, p. 54

nevirapine  
Nexium (esomeprazole) – **PA**; see Table 3, p. 37  
niacin \*  
niacin/lovastatin – **PA**; see Table 13, p. 47  
niacinamide \*  
nicardipine – see Table 22, p. 56  
nicotinic acid \*  
Nifedical (nifedipine) – see Table 22, p. 56  
nifedipine – see Table 22, p. 56  
Nilandron (nilutamide)  
Nilstat # (nystatin)  
nilutamide  
nimodipine – see Table 22, p. 56  
Nimotop (nimodipine) – see Table 22, p. 56  
nisoldipine – **PA**; see Table 22, p. 56  
nitazoxanide suspension – **PA > 12 years**  
nitazoxanide tablet – **PA**  
nitisinone  
Nitrek # (nitroglycerin)  
Nitro-Bid # (nitroglycerin)  
Nitrodisc (nitroglycerin)  
Nitro-Dur # (nitroglycerin)  
nitrofurantoin  
nitrofurazone  
nitroglycerin  
Nitrol (nitroglycerin)  
Nitrolingual (nitroglycerin)  
Nitroquick (nitroglycerin)  
Nitrostat # (nitroglycerin)  
Nitrotab (nitroglycerin)  
Nitro-Time (nitroglycerin)  
nizatidine – **PA**; see Table 3, p. 37  
Nizoral # (ketoconazole)  
Nolvadex # (tamoxifen)  
nonoxynol-9 \*  
Norco # (hydrocodone/acetaminophen) – see Table 8, p. 42  
Nordette # (ethinyl estradiol/levonorgestrel)  
Norditropin (somatropin) – **PA**; see Table 9, p. 43  
norethindrone  
Norflex # (orphenadrine) – see Table 7, p. 41  
norfloxacin  
Norgesic # (orphenadrine/aspirin/cafeine) – see Table 7, p. 41  
Norgestimate/ethinyl estradiol  
norgestrel  
Norinyl # (ethinyl estradiol/norethindrone)  
Noritate (metronidazole)

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## Alphabetic List (cont.)

Normodyne # (labetalol) – see Table 21, p. 55  
Noroxin (norfloxacin)  
Norpace # (disopyramide)  
Norpramin # (desipramine) – see Table 17, p. 51  
Nor-Q-D # (norethindrone)  
Nortrel (ethinyl estradiol/norethindrone)  
nortriptyline – see Table 17, p. 51  
Norvasc (amlodipine) – **PA**; see Table 22, p. 56  
Norvir (ritonavir)  
Novantrone (mitoxantrone) – see Table 5, p. 39  
Novoseven (eptacog alfa)  
Nulev (hyoscyamine)  
NuLytely (polyethylene glycol-electrolyte solution)  
Numorphan (oxymorphone) – see Table 8, p. 42  
Nutropin (somatropin) – **PA**; see Table 9, p. 43  
Nutropin AQ (somatropin) – **PA**; see Table 9, p. 43  
NuvaRing (etonogestrel/ethinyl estradiol)  
nystatin  
nystatin/neomycin/triamcinolone/gramicidin  
nystatin/triamcinolone

## O

octreotide  
Ocufen # (flurbiprofen)  
Ocuflox # (ofloxacin)  
Ocupress # (carteolol)  
Ocusulf-10 # (sulfacetamide)  
ofloxacin  
Ogen # (estropipate)  
Ogestrel # (ethinyl estradiol/norgestrel)  
olanzapine – see Table 24, p. 58  
olanzapine injection – **PA**  
olanzapine, orally disintegrating tablets – **PA**;  
see Table 24, p. 58  
olanzapine/fluoxetine – **PA**; see Table 17, p. 51;  
see Table 24, p. 58  
olmesartan – **PA**; see Table 18, p. 52  
olopatadine  
olsalazine  
Olux (clobetasol) – **PA**; see Table 16, p. 50  
omalizumab – **PA**  
omeprazole – **PA**; see Table 3, p. 37  
Omnicef (cefdinir)  
Omnipen # (ampicillin)

OMS (morphine) – **PA > 360 mg/day**; see Table 8, p. 42  
ondansetron 4 mg, 8 mg – **PA > 15 units/month**;  
see Table 27, p. 61  
ondansetron 24 mg – **PA > 5 units/month**; see  
Table 27, p. 61  
ondansetron solution – **PA > 50 mL/month**; see  
Table 27, p. 61  
Onxol # (paclitaxel)  
opium  
oprelvekin – **PA**; see Table 4, p. 38  
Opticrom # (cromolyn)  
Optimine (azatadine) – **PA**; see Table 12, p. 46  
Optipranolol # (metipranolol)  
Optivar (azelastine)  
Oralene # (triamcinolone)  
Oramorph SR (morphine) – **PA > 360 mg/day**; see  
Table 8, p. 42  
Orap (pimozide)  
Orapred (prednisolone)  
Orasone (prednisone)  
Oretic # (hydrochlorothiazide)  
Orfadin (nitisinone)  
orphenadrine – see Table 7, p. 41  
orphenadrine/aspirin/caffeine – see Table 7, p. 41  
Orphengesic # (orphenadrine/aspirin/caffeine) – see  
Table 7, p. 41  
Ortho-Cept # (ethinyl estradiol/desogestrel)  
Ortho-Cyclen (ethinyl estradiol/norgestimate)  
Ortho-Dienestrol (dienestrol)  
Ortho-Est # (estropipate)  
Ortho-Evra (ethinyl estradiol/norelgestromin)  
Ortho-Novum # (ethinyl estradiol/norethindrone)  
Ortho-Prefest (estradiol/norgestimate)  
OrthoTri-Cyclen (ethinyl estradiol/norgestimate)  
OrthoTri-Cyclen Lo (ethinyl estradiol/norgestimate)  
Orthovisc (hyaluronan) – **PA**  
Orudis # (ketoprofen \*) – see Table 11, p. 45  
Oruvail # (ketoprofen \*) – see Table 11, p. 45  
oseltamivir – **PA > 10 capsules/month**  
Osmoglyn (glycerin)  
Oticaine (benzocaine)  
Otocain (benzocaine)  
Ovcon (ethinyl estradiol/norethindrone)  
Ovide (malathion)  
Ovral # (ethinyl estradiol/norgestrel)  
Ovrette (norgestrel)  
oxacillin

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## Alphabetic List (cont.)

oxaliplatin  
Oxandrin (oxandrolone) – **PA**  
oxandrolone – **PA**  
oxaprozin – see Table 11, p. 45  
oxazepam  
oxcarbazepine – see Table 20, p. 54  
oxiconazole  
Oxistat (oxiconazole)  
Oxsoralen (methoxsalen)  
Oxsoralen-Ultra (methoxsalen)  
oxybutynin  
oxybutynin patch – **PA**  
oxycodone powder – **PA**; see Table 8, p. 42  
oxycodone controlled release – **PA**; see Table 8, p. 42  
oxycodone immediate release – **PA > 240 mg/day**; see Table 8, p. 42  
oxycodone/acetaminophen – see Table 8, p. 42  
oxycodone/aspirin – see Table 8, p. 42  
OxyContin (oxycodone controlled release) – **PA**; see Table 8, p. 42  
Oxydose (oxycodone) – **PA > 240 mg/day**; see Table 8, p. 42  
OxyFast (oxycodone) – **PA > 240 mg/day**; see Table 8, p. 42  
Oxy IR (oxycodone) – **PA > 240 mg/day**; see Table 8, p. 42  
oxymetholone  
oxymorphone  
oxytetracycline/polymyxin B  
oxytocin  
Oxytrol (oxybutynin) patch – **PA**

**P**

P2E1 (pilocarpine/epinephrine)  
Pacerone # (amiodarone)  
paclitaxel  
palivizumab – **PA**  
Palladone (hydromorphone extended-release capsules) – **PA**; see Table 8, page 42  
palonosetron  
Pamelor # (nortriptyline) – see Table 17, p. 51  
pamidronate  
Pamine (methscopolamine)  
Panafil (papain/urea/chlorophyllin/copper complex)  
Pancrease (amylase/lipase/protease)  
Pancrecarb (amylase/lipase/protease)  
Pancrelipase (amylase/lipase/protease)  
Pancron (amylase/lipase/protease)  
Pandel (hydrocortisone) – **PA**; see Table 16, p. 50  
Pangestyme (amylase/lipase/protease)  
Panglobulin (immune globulin IV, human) – **PA**; see Table 1, p. 35  
Panokase (amylase/lipase/protease)  
Panretin (alitretinoin) – **PA**; see Table 10, p. 44  
pantoprazole – see Table 3, p. 37  
papain/urea  
papain/urea/chlorophyllin  
papain/urea/chlorophyllin/copper complex  
papaverine  
Parafor Forte DSC # (chlorzoxazone) – see Table 7, p. 41  
Paragard (copper IUD)  
Paraplatin (carboplatin)  
Parcopa (carbidopa/levodopa, orally disintegrating tablet) – **PA**  
paregoric  
paricalcitol  
Parlodel # (bromocriptine)  
Parnate (tranylcypromine) – see Table 17, p. 51  
paromomycin  
paroxetine ° – see Table 17, p. 51  
paroxetine controlled release – **PA**; see Table 17, p. 51  
Patanol (olopatadine)  
Paxil # (paroxetine) – see Table 17, p. 51  
Paxil CR (paroxetine controlled release) – **PA**; see Table 17, p. 51  
PBZ # (tripelennamine) – see Table 12, p. 46  
PCE Dispertab (erythromycin)  
Pediapred # (prednisolone)  
pediatric multivitamins \*  
Pedi-Dri (nystatin)  
Peditic # (neomycin/polymyxin B/hydrocortisone)  
Peganone (ethotoin) – see Table 20, p. 54  
Pegasys (peginterferon alfa-2a) – **PA > 4 doses/month**; see Table 5, p. 39  
pegfilgrastim – **PA**; see Table 4, p. 38  
peginterferon alfa-2a – **PA > 4 doses/month**; see Table 5, p. 39  
peginterferon alfa-2b – **PA > 4 doses/month**; see Table 5, p. 39

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## Alphabetic List (cont.)

PEG-Intron (peginterferon alfa-2b) – **PA** > 4

**doses/month**; see Table 5, p. 39

pegvisomant – **PA**

Pemadd # (pemoline)

pemetrexed

pemirolast

pemoline

penbutolol – **PA**; see Table 21, p. 55

penciclovir

penicillamine

penicillin G

penicillin V

Penlac (ciclopirox)

pentamidine

Pentasa (mesalamine)

pentazocine

pentazocine/acetaminophen

pentazocine/naloxone

pentosan

pentoxifylline

Pentoxil # (pentoxifylline)

Pepcid # (famotidine \*) – see Table 3, p. 37

P-Ephrine (phenylephrine)

Percocet (oxycodone/acetaminophen) – **PA**; see Table 8, p. 42

Percodan # (oxycodone/aspirin) – see Table 8, p. 42

pergolide

Periactin # (cyproheptadine) – see Table 12, p. 46

perindopril – **PA**; see Table 18, p. 52

Periostat (doxycycline)

Permapen (penicillin G)

Permax # (pergolide)

permethrin \*

perphenazine

petrolatum \*

Pexeva (paroxetine) – **PA**; see Table 17, p. 51

Pfizerpen # (penicillin G)

Pharmaflur (sodium fluoride)

phenazopyridine

phenelzine – see Table 17, p. 51

Phenergan # (promethazine) – see Table 12, p. 46

phenobarbital – see Table 20, p. 54

phentolamine

phenylephrine

phenyltoloxamine/pyrilamine/pheniramine/

pseudoephedrine – see Table 12, p. 46

Phenytek (phenytoin) – see Table 20, p. 54

phenytoin – see Table 20, p. 54

PhisoHex (hexachlorophene)

Phos-Flur (sodium fluoride)

Phoslo (calcium acetate)

Phospholine Iodide (echothiophate)

Phrenilin # (butalbital/acetaminophen)

phytonadione

Pilocar # (pilocarpine)

pilocarpine

pilocarpine/epinephrine

Pilopine (pilocarpine)

Piloptic (pilocarpine)

pimecrolimus

pimozide

pindolol – see Table 21, p. 55

pioglitazone – see Table 26, p. 60

piperacillin/tazobactam

pirbuterol – **PA**; see Table 23, p. 57

piroxicam – see Table 11, p. 45

Plan B (levonorgestrel)

Plaquenil # (hydroxychloroquine)

Platinol-AQ # (cisplatin)

Plavix (clopidogrel)

Plenaxis (abarelix) – **PA**

Plendil (felodipine) – **PA**; see Table 22, p. 56

Pletal (cilostazol)

Plexion (sulfacetamide/sulfur)

pneumococcal vaccine

Pneumovax (pneumococcal vaccine)

Pnu-Imune # (pneumococcal vaccine)

podofilox

Polaramine # (dexchlorpheniramine) – see Table 12, p. 46

Polycitra (citric acid/sodium citrate/potassium citrate)

Polycitra-K (citric acid/potassium citrate)

Polycitra-LC (citric acid/sodium citrate/potassium citrate)

polyethylene glycol

polyethylene glycol-electrolyte solution

Polygam S/D (immune globulin IV, human) – **PA**; see Table 1, p. 35

polymyxin B

Poly-Pred (neomycin/polymyxin B/prednisolone)

polythiazide

Polytrim # (trimethoprim/polymyxin B)

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## Alphabetic List (cont.)

Ponstel (mefenamic acid) – **PA**; see Table 11, p. 45  
Portia (levonorgestrel/ethinyl estradiol)  
potassium bicarbonate  
potassium chloride/potassium bicarbonate  
potassium chloride/sodium chloride/sodium bicarbonate  
potassium citrate  
potassium citrate/citric acid  
potassium citrate/sodium citrate/citric acid  
potassium iodide  
potassium phosphate  
potassium phosphate/dibasic sodium phosphate/monobasic sodium phosphate  
potassium phosphate/sodium phosphate  
potassium phosphate/sodium phosphate/phosphorus  
povidone \*  
pramipexole  
Pramosone # (pramoxine/hydrocortisone)  
pramoxine/hydrocortisone  
Prandin (repaglinide) – **PA**; see Table 26, p. 60  
Pravachol (pravastatin) – **PA**; see Table 13, p. 47  
pravastatin – **PA**; see Table 13, p. 47  
pravastatin/aspirin – **PA**; see Table 13, p. 47  
Pravigard PAC (pravastatin/aspirin) – **PA**; see Table 13, p. 47  
prazosin – see Table 19, p. 53  
prazosin/polythiazide – see Table 19, p. 53  
Precose (acarbose) – **PA**; see Table 26, p. 60  
Pred-Forte # (prednisolone)  
Pred-G (prednisolone/gentamicin)  
prednicarbate – **PA**; see Table 16, p. 50  
prednisolone  
prednisolone/gentamicin  
prednisone  
Prelone # (prednisolone)  
Premarin (estrogens, conjugated)  
Premphase (medroxyprogesterone/estrogens, conjugated)  
Prempro (medroxyprogesterone/estrogens, conjugated)  
prenatal vitamins \*  
Prevacid (lansoprazole) capsule – **PA > 16 years**; see Table 3, p. 37  
Prevacid IV (lansoprazole) – **PA**; see Table 3, p. 37

Prevacid NapraPAC (lansoprazole/naproxen) – **PA**; see Table 11, p. 45  
Prevacid SoluTab (lansoprazole, orally disintegrating tablet) – **PA > 16 years**; see Table 3, p. 37  
Prevacid (lansoprazole) suspension – **PA > 16 years (except for LTC members)**; see Table 3, p. 37  
Prevalite # (cholestyramine)  
Preven (ethinyl estradiol/levonorgestrel)  
Prevident (sodium fluoride)  
Prevpac (lansoprazole/amoxicillin/clarithromycin)  
Prilosec (omeprazole) – **PA**; see Table 3, p. 37  
primaquine  
Primaxin (imipenem/cilastatin)  
primidone – see Table 20, p. 54  
Primsol (trimethoprim)  
Principen # (ampicillin)  
Prinivil # (lisinopril) – see Table 18, p. 52  
Prinzide # (lisinopril/hydrochlorothiazide) – see Table 18, p. 52  
Proamatine (midodrine)  
probenecid  
probenecid/colchicine  
procainamide  
Procanbid (procainamide)  
procarbazine  
Procardia # (nifedipine) – see Table 22, p. 56  
prochlorperazine  
Procrit (epoetin alfa) – **PA**; see Table 4, p. 38  
Proctocort # (hydrocortisone)  
Proctocream-HC # (pramoxine/hydrocortisone)  
Proctofoam-HC (pramoxine/hydrocortisone)  
Procto-Kit # (hydrocortisone)  
Proctozone-HC # (hydrocortisone)  
procyclidine  
Profilnine SD (factor IX complex)  
progesterone  
Proglycem (diazoxide)  
Prograf (tacrolimus)  
Prolastin (alpha1–proteinase inhibitor–human)  
Prolixin # (fluphenazine)  
Proloprim # (trimethoprim)  
promethazine – see Table 12, p. 46  
promethazine/phenylephrine – see Table 12, p. 46  
Promethegan (promethazine)  
Prometrium (progesterone)  
Pronestyl # (procainamide)

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## Alphabetic List (cont.)

propafenone  
propantheline  
Propine # (dipivefrin)  
Proplex T (factor IX complex)  
propoxyphene – see Table 8, p. 42  
propoxyphene napsylate – see Table 8, p. 42  
propoxyphene napsylate/acetaminophen – see Table 8, p. 42  
propranolol – see Table 21, p. 55  
propranolol extended-release – **PA**; see Table 21, p. 55  
propranolol/hydrochlorothiazide – see Table 21, p. 55  
propylthiouracil  
Proscar (finasteride) – **PA**  
Prosed/DS (methenamine/benzoic/acid/atropine/hyoscyamine/saldol/methylene blue)  
ProSom # (estazolam) – **PA > 10 units/month**; see Table 15, p. 49  
Prostigmin (neostigmine)  
Protonix (pantoprazole) – see Table 3, p. 37  
Protopic (tacrolimus)  
protriptyline – see Table 17, p. 51  
Protropin (somatrem) – **PA**; see Table 9, p. 43  
Proventil #  
Proventil, inhaler (albuterol) – **PA**; see Table 23, p. 57  
Proventil HFA, inhaler (albuterol) – **PA**; see Table 23, p. 57  
Provera # (medroxyprogesterone)  
Provigil (modafinil) – **PA**  
Prozac # (fluoxetine) – see Table 17, p. 51  
Prozac Weekly (fluoxetine) – **PA**; see Table 17, p. 51  
Prudoxin (doxepin)  
pseudoephedrine \*  
Psorcon # (diflorasone) – see Table 16, p. 50  
psyllium \*  
Pulmicort (budesonide), inhalation suspension – see Table 23, p. 57  
Pulmicort (budesonide), inhaler – see Table 23, p. 57  
Pulmozyme (dornase alpha)  
Purinethol # (mercaptopurine)  
pyrazinamide  
Pyridium (phenazopyridine)  
pyridostigmine bromide  
pyridoxine \*

pyrilamine/phenylephrine – see Table 12, p. 46  
pyrimethamine

## Q

quazepam – **PA**; see Table 15, p. 49  
Questran # (cholestyramine)  
quetiapine – see Table 24, p. 58  
Quibron (theophylline/guafenesin)  
Quibron-T/SR (theophylline)  
quinacrine  
Quinaglute # (quinidine)  
quinapril – **PA**; see Table 18, p. 52  
quinapril/hydrochlorothiazide – **PA**; see Table 18, p. 52  
Quinidex # (quinidine)  
quinidine  
quinine  
Quixin (levofloxacin)  
Qvar (beclomethasone), inhaler – see Table 23, p. 57

## R

Rabavert (rabies vaccine)  
rabeprazole – **PA**; see Table 3, p. 37  
rabies immune globulin IM, human – see Table 1, p. 35  
rabies vaccine  
Radiacare (oxybenzone/pedimate)  
raloxifene  
ramipril – **PA**; see Table 18, p. 52  
ranitidine \* – see Table 3, p. 37  
ranitidine, effervescent tablet – **PA**; see Table 3, p. 37  
Rapamune (sirolimus)  
Raptiva (efalizumab) – **PA**; see Table 5, p. 39  
rasburicase  
Rebetol (ribavirin) – **PA**  
Rebetol solution (ribavirin) – **PA > 18 years**  
Rebetron (interferon alfa-2b/ribavirin) – **PA**; see Table 5, p. 39  
Rebif (interferon beta-1a) – see Table 5, p. 39  
Recombinate (antihemophilic factor, recombinant)  
Recombivax HB (hepatitis B, recombinant vaccine)  
Refacto (antihemophilic factor, recombinant)  
Refludan (lepirudin) – **PA**  
Regitine (phentolamine)  
Reglan # (metoclopramide)

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## Alphabetic List (cont.)

Regranex (becaplermin)  
Relafen # (nabumetone) – see Table 11, p. 45  
Relenza (zanamivir) – **PA > 20 units/month**  
Relpax (eletriptan) – **PA**; see Table 14, p. 48  
Remeron # (mirtazapine) – see Table 17, p. 51  
Remeron Sol Tab (mirtazapine, orally disintegrating tablet) – **PA**; see Table 17, p. 51  
Remicade (infliximab) – **PA**; see Table 5, p. 39  
Reminyl (galantamine)  
Remodulin (treprostinil)  
Remular-S # (chlorzoxazone)  
Renacidin (magnesium carbonate/citric acid/gluconolactone)  
Renagel (sevelamer)  
Renese (polythiazide)  
repaglinide – **PA**; see Table 26, p. 60  
Repan # (butalbital/acetaminophen/cafeine)  
Repan-CF # (butalbital/acetaminophen)  
Prepexain (hydrocodone/ibuprofen) – **PA**; see Table 8, p. 42  
Requip (ropinirole)  
Rescriptor (delavirdine)  
Rescula (unoprostone)  
reserpine  
RespiGam (respiratory syncytial virus immune globulin IV) – **PA**; see Table 1, p. 35  
respiratory syncytial virus immune globulin IV – **PA**; see Table 1, p. 35  
Restasis (cyclosporine)  
Restoril # (temazepam) – **PA > 10 units/month**; see Table 15, p. 49  
Retin-A # (tretinoin) – **PA > 25 years**; see Table 10, p. 44  
Retinol \*  
Retrovir (zidovudine)  
Revia # (naltrexone)  
Reyataz (atazanavir)  
Rheumatrex # (methotrexate)  
Rhinocort Aqua (budesonide, nasal spray) – **PA > 1 inhaler/2 months**; see Table 25, p. 59  
Rho(D) immune globulin IM – see Table 1, p. 35  
Rho(D) immune globulin IM micro-dose – see Table 1, p. 35  
Rho(D) immune globulin IV, human – see Table 1, p. 35  
RhoGAM (Rho(D) immune globulin IM) – see Table 1, p. 35  
RhoPhylac (Rho (D) immune globulin IV, human) – see Table 1, p. 35  
ribavirin  
ribavirin solution – **PA > 18 years**  
riboflavin \*  
Ridaura (auranofin)  
rifabutin  
Rifadin # (rifampin)  
Rifamate (rifampin/isoniazid)  
rifampin  
rifampin/isoniazid  
rifaximin  
Rilutek (riluzole)  
riluzole  
Rimactane # (rifampin)  
rimantadine  
rimexolone  
Riomet (metformin solution) – see Table 26, p. 60  
risedronate  
Risperdal (risperidone) – see Table 24, p. 58  
Risperdal Consta (risperidone injection) – see Table 24, p. 58  
Risperdal M (risperidone, orally disintegrating tablet) – **PA**; see Table 24, p. 58  
risperidone – see Table 24, p. 58  
risperidone injection – see Table 24, p. 58  
risperidone, orally disintegrating tablet – **PA**; see Table 24, p. 58  
Ritalin # (methylphenidate)  
ritonavir  
ritonavir/lopinavir  
Rituxan (rituximab)  
rituximab  
rivastigmine  
rizatriptan – **PA**; see Table 14, p. 48  
rizatriptan, orally disintegrating tablets – **PA**; see Table 14, p. 48  
RMS (morphine) – see Table 8, p. 42  
Robaxin # (methocarbamol) – see Table 7, p. 41  
Robinul # (glycopyrrolate)  
Rocaltrol # (calcitriol)  
Rocephin (ceftriaxone)  
Roferon-A (interferon alfa-2a) – see Table 5, p. 39  
ropinirole  
rosiglitazone – see Table 26, p. 60  
rosiglitazone/metformin – **PA**; see Table 26, p. 60

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## Alphabetic List (cont.)

rosuvastatin – **PA > 30 units/month**; see Table 13, p. 47  
Rowasa # (mesalamine)  
Roxanol (morphine) – **PA > 360 mg/day**; see Table 8, p. 42  
Roxanol-T (morphine) – **PA > 360 mg/day**; see Table 8, p. 42  
Roxicet (oxycodone/acetaminophen) – see Table 8, p. 42  
Roxicodone (oxycodone) – **PA > 240 mg/day**; see Table 8, p. 42  
Roxiprin (oxycodone/aspirin) – see Table 8, p. 42  
Rozex (metronidazole)  
Rx-Otic (antipyrine/benzocaine)  
Rythmol # (propafenone)

## S

Saizen (somatropin) – **PA**; see Table 9, p. 43  
Salagen (pilocarpine)  
salicylic acid/sulfur colloidal  
salmeterol – see Table 23, p. 57  
salsalate  
Sal-Tropine (atropine)  
Sanctura (trospium)  
Sandimmune # (cyclosporine)  
Sandoglobulin (immune globulin IV, human) – **PA**; see Table 1, p. 35  
Sandostatin (octreotide)  
Sansert (methysergide)  
Santyl (collagenase)  
saquinavir  
Sarafem (fluoxetine) – **PA**; see Table 17, p. 51  
sargramostim – **PA**; see Table 4, p. 38  
scopolamine  
scopolamine/phenylephrine  
Seasonale (ethinyl estradiol/levonorgestrel)  
secobarbital  
secobarbital/amobarbital  
Seconal # (secobarbital)  
Sectral # (acebutolol) – see Table 21, p. 55  
selegiline  
selenium sulfide \*  
Semprex-D (acrivastine/pseudoephedrine) – **PA**; see Table 12, p. 46  
senna \*  
Sensipar (cinacalcet) – **PA**

Sensorcaine # (bupivacaine)  
Septisol (hexachlorophene)  
Septra # (trimethoprim/sulfamethoxazole)  
Serax # (oxazepam)  
Serentil (mesoridazine)  
Serevent (salmeterol) – see Table 23, p. 57  
Seroquel (quetiapine) – see Table 24, p. 58  
Serostim (somatropin) – **PA**; see Table 9, p. 43  
sertaconazole – **PA**  
sertraline – **PA**; see Table 17, p. 51  
Serzone # (nefazodone) – see Table 17, p. 51  
sevelamer  
Shohl's Solution (sodium citrate/citric acid)  
Sildec (carbinoxamine/pseudoephedrine)  
sildenafil – **PA**; see Table 6, p. 40  
Silvadene # (silver sulfadiazine)  
silver sulfadiazine  
simethicone \*  
simvastatin – **PA**; see Table 13, p. 47  
Sinemet # (carbidopa/levodopa)  
Sinequan # (doxepin) – see Table 17, p. 51  
Singulair (montelukast) – **PA > 16 years**  
sirolimus  
Skelaxin (metaxalone) – see Table 7, p. 41  
Skelid (tiludronate)  
Slo-Bid # (theophylline)  
Slo-Phyllin (theophylline)  
sodium bicarbonate \*  
sodium chloride solution for inhalation \*  
sodium citrate/citric acid  
sodium ferric gluconate complex  
sodium fluoride  
sodium phenylbutyrate  
sodium phosphate  
sodium polystyrene sulfonate  
Solaraze (diclofenac)  
Solganal (aurothioglucose)  
Solu-Cortef # (hydrocortisone)  
Solu-Medrol # (methylprednisolone)  
Soma # (carisoprodol) – see Table 7, p. 41  
somatrem – **PA**; see Table 9, p. 43  
somatropin – **PA**; see Table 9, p. 43  
Somavert (pegvisomant) – **PA**  
Somnote (chloral hydrate)  
Sonata (zaleplon) – **PA > 10 units/month**; see Table 15, p. 49  
Sorbitrate # (isosorbide)  
Soriatane (acitretin) – see Table 10, p. 44

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**°** Prior-authorization status depends on the drug's formulation.

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## Alphabetic List (cont.)

sotalol – see Table 21, p. 55  
Spectazole # (econazole)  
Spectracef (cefditoren)  
Spiriva (tiotropium)  
spironolactone  
spironolactone/hydrochlorothiazide  
Sporanox (itraconazole)  
SPS # (sodium polystyrene sulfonate)  
SSKI (potassium iodide)  
Stadol, injection # (butorphanol)  
Stadol, nasal spray (butorphanol) – **PA**  
Stalevo (carbidopa/levodopa/entacapone) – **PA**  
stanazolol  
Starlix (nateglinide) – **PA**; see Table 26, p. 60  
Stelazine # (trifluoperazine)  
Stimate (desmopressin)  
Strattera (atomoxetine) – **PA**  
Stromectol (ivermectin)  
Suboxone (buprenorphine/naloxone)  
Subutex (buprenorphine)  
succimer  
sucralfate  
Sular (nisoldipine) – **PA**; see Table 22, p. 56  
sulconazole  
sulfacetamide  
sulfacetamide/prednisolone  
sulfacetamide/sulfur  
Sulfacet-R (sulfacetamide/sulfur)  
sulfadiazine  
Sulfamide (sulfacetamide)  
Sulfamylon (mafenide)  
sulfanilamide  
sulfasalazine  
Sulfatrim # (trimethoprim/sulfamethoxazole)  
Sulfazine # (sulfasalazine)  
sulfinpyrazone  
sulfisoxazole  
Sulfoxyl (benzoyl peroxide/sulfur)  
sulindac – see Table 11, p. 45  
sumatriptan, injection – **PA > 2 units (4 injections)/month**; see Table 14, p. 48  
sumatriptan, nasal spray – **PA**; see Table 14, p. 48  
sumatriptan, tablet – **PA**; see Table 14, p. 48  
Sumycin # (tetracycline)  
Suprax (cefixime)  
Surmontil (trimipramine) – see Table 17, p. 51  
Sustiva (efavirenz)

Symbyax (fluoxetine/olanzapine) – **PA**; see Table 17, p. 51; see Table 24, p. 58  
Symmetrel # (amantadine)  
Synagis (palivizumab) – **PA**  
Synalar # (fluocinolone) – see Table 16, p. 50  
Synalgos-DC (dihydrocodeine/aspirin/cafeine)  
Synarel (nafarelin) – **PA**; see Table 2, p. 36  
Synthroid # (levothyroxine)  
Synvisc (hylan polymers) – **PA**  
Syprine (trientine)

## T

tacrine  
tacrolimus  
tadalafil – **PA**; see Table 6, p. 40  
Tagamet # (cimetidine \*) – see Table 3, p. 37  
Talacen # (pentazocine/acetaminophen)  
Talwin (pentazocine)  
Tambocor (flecainide)  
Tamiflu (oseltamivir) – **PA > 10 capsules/month**  
tamoxifen  
tamsulosin – **PA**; see Table 19, p. 53  
TAO (troleandomycin)  
Tapazole # (methimazole)  
Targretin (bexarotene)  
Tarka (trandolapril/verapamil) – **PA**; see Table 18, p. 52; see Table 22, p. 56  
Tasmar (tolcapone)  
Tavist # (clemastine) – see Table 12, p. 46  
Taxol # (paclitaxel)  
Taxotere (docetaxel)  
tazarotene – **PA > 25 years**; see Table 10, p. 44  
Tazicef # (ceftazidime)  
Tazidime # (ceftazidime)  
Tazorac (tazarotene) – **PA > 25 years**; see Table 10, p. 44  
TBC # (trypsin/balsam peru/castor oil)  
tegaserod – **PA**  
Tegison (etretinate) – see Table 10, p. 44  
Tegretol # (carbamazepine) – see Table 20, p. 54  
telithromycin  
telmisartan – **PA**; see Table 18, p. 52  
temazepam – **PA > 10 units/month**; see Table 15, p. 49  
Temodar (temozolomide)  
Temovate # (clobetasol) – see Table 16, p. 50

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## Alphabetic List (cont.)

temozolomide  
Tenex # (guanfacine)  
tenofovir  
Tenoretic # (atenolol/chlorthalidone) – see Table 21, p. 55  
Tenormin # (atenolol) – see Table 21, p. 55  
Tequin (gatifloxacin)  
Terak (oxytetracycline/polymyxin B)  
Terazol # (terconazole)  
terazosin – see Table 19, p. 53  
terbinafine  
terbutaline  
terconazole  
teriparatide – **PA**  
Teslac (testolactone)  
Testim (testosterone)  
Testoderm (testosterone)  
testolactone  
testosterone  
Testred (methyltestosterone)  
tetanus immune globulin IM, human – see Table 1, p. 35  
tetracycline  
Teveten (eprosartan) – **PA**; see Table 18, p. 52  
Texacort # (hydrocortisone) – see Table 16, p. 50  
thalidomide – see Table 5, p. 39  
Thalitone (chlorthalidone)  
Thalomid (thalidomide) – see Table 5, p. 39  
Theo-24 (theophylline)  
Theochron # (theophylline)  
Theo-Dur # (theophylline)  
Theolair (theophylline)  
Theolair-SR # (theophylline)  
Theolate (theophylline/guaifenesin)  
theophylline  
theophylline/guaifenesin  
theophylline/potassium iodide  
Thera-Flur-N (sodium fluoride)  
Thermazene # (silver sulfadiazine)  
thiabendazole  
thiamine \*  
thiethylperazine  
thioguanine  
Thiola (tiopronin)  
thioridazine  
thiothixene  
Thorazine # (chlorpromazine)  
Thymoglobulin (antithymocyte globulin, rabbit) – see Table 1, p. 35  
thyroid  
Thyrolar (liotrix)  
Thyrox (levothyroxine)  
tiagabine – **PA > 18 years**; see Table 20, p. 54  
Tiazac (diltiazem) – see Table 22, p. 56  
ticarcillin/clavulanate  
TICE BCG (BCG vaccine)  
Ticlid # (ticlopidine)  
ticlopidine  
Tikosyn (dofetilide)  
Tilade (nedocromil) – see Table 23, p. 57  
tiludronate  
Timentin (ticarcillin/clavulanate)  
Timolide (timolol/hydrochlorothiazide) – see Table 21, p. 55  
timolol – see Table 21, p. 55  
timolol/hydrochlorothiazide – see Table 21, p. 55  
Timoptic # (timolol)  
Tindamax (tinidazole) – **PA**  
tinidazole – **PA**  
tiopronin  
tiotropium  
tizanidine – see Table 7, p. 41  
TOBI (tobramycin/sodium chloride)  
TobraDex (tobramycin/dexamethasone)  
tobramycin  
tobramycin/dexamethasone  
tobramycin/sodium chloride  
Tobrex # (tobramycin)  
tocainide  
Tofranil # (imipramine) – see Table 17, p. 51  
tolazamide – see Table 26, p. 60  
tolbutamide – see Table 26, p. 60  
tolcapone  
Tolectin # (tolmetin) – see Table 11, p. 45  
Tolinase # (tolazamide) – see Table 26, p. 60  
tolmetin – see Table 11, p. 45  
tolnaftate \*  
tolterodine  
Tonocard (tocainide)  
Topamax (topiramate) – **PA > 18 years**; see Table 20, p. 54  
Topicort # (desoximetasone) – see Table 16, p. 50  
Topicort LP # (desoximetasone) – see Table 16, p. 50

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## Alphabetic List (cont.)

topiramate – **PA > 18 years**; see Table 20, p. 54  
Toprol (metoprolol) – see Table 21, p. 55  
Toradol # (ketorolac) – **PA > 20 units/month**;  
see Table 11, p. 45  
Torecan (thiethylperazine)  
toremifene  
torsemide  
tositumomab – **PA**  
T-Phyl (theophylline)  
Tracleer (bosentan)  
tramadol  
tramadol/acetaminophen – **PA**  
Trandate # (labetalol) – see Table 21, p. 55  
trandolapril – **PA**; see Table 18, p. 52  
trandolapril/verapamil – **PA**; see Table 18, p. 52;  
see Table 22, p. 56  
Transderm-Nitro (nitroglycerin)  
Transderm-Scop (scopolamine)  
Tranxene T # (clorazepate) – see Table 20,  
p. 54  
tranylcypromine – see Table 17, p. 51  
trastuzumab  
Travasol (amino acid and electrolyte IV infusion)  
Travatan (travoprost)  
travoprost  
trazodone – see Table 17, p. 51  
Trelstar (triptorelin) – **PA**; see Table 2, p. 36  
Trental # (pentoxifylline)  
treprostinil  
tretinoin – **PA > 25 years**; see Table 10, p. 44  
Trexall (methotrexate)  
triamcinolone, inhaler – see Table 23, p. 57  
triamcinolone, nasal spray – **PA > 1**  
**inhaler/month**; see Table 25, p. 59  
triamcinolone, oral  
triamcinolone, topical – see Table 16, p. 50  
triamterene/hydrochlorothiazide  
triazolam – **PA > 10 units/month**; see Table 15,  
p. 49  
Tri-Chlor (trichloroacetic acid)  
trichlormethiazide  
trichloroacetic acid  
Tricor # (fenofibrate)  
Tricosal (choline salicylate/magnesium  
salicylate)  
trientine  
triethanolamine  
trifluoperazine

trifluridine  
trihexyphenidyl  
Trilafon # (perphenazine)  
Trileptal (oxcarbazepine) – see Table 20, p. 54  
Tri-Levlen # (ethinyl estradiol/levonorgestrel)  
Trilisate (choline salicylate/magnesium salicylate)  
trimethoprim  
trimethoprim/polymyxin B  
trimethoprim/sulfamethoxazole  
trimipramine – see Table 17, p. 51  
Trimox # (amoxicillin)  
Trinalin Repetabs (azatadine/pseudoephedrine) –  
**PA**; see Table 12, p. 46  
Tri-Norinyl (ethinyl estradiol/norethindrone)  
tripelennamine – see Table 12, p. 46  
Triphasil # (ethinyl estradiol/levonorgestrel)  
triprolidine/pseudoephedrine  
triptorelin – **PA**; see Table 2, p. 36  
Tri-Statil II (nystatin/triamcinolone)  
Trivora # (ethinyl estradiol/levonorgestrel)  
Trizivir (abacavir/lamivudine/zidovudine)  
troleandomycin  
tropicamide  
trospium  
Trusopt (dorzolamide)  
Truvada (emtricitabine/tenofovir)  
trypsin/balsam peru/castor oil  
Tuinal (secobarbital/amobarbital)  
Twinrix (hepatitis A, inactivated/hepatitis B,  
recombinant vaccine)  
Tylenol/codeine # (codeine/acetaminophen) – see  
Table 8, p. 42  
Tylox # (oxycodone/acetaminophen) – see Table 8,  
p. 42  
Typhim Vi (typhoid vaccine)  
typhoid vaccine

## U

Udamin (folic acid/multivitamin) – **PA**  
Udamin SP (folic acid/multivitamin/saw palmetto) –  
**PA**  
Ultracet (tramadol/acetaminophen) – **PA**  
Ultram # (tramadol)  
Ultrase (amylase/lipase/protease)  
Ultravate (halobetasol) – **PA**; see Table 16,  
p. 50  
Umecta (urea) – **PA**

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## Alphabetic List (cont.)

Unasyn (ampicillin/sulbactam)  
Uni-Dur (theophylline)  
Uniphyll # (theophylline)  
Uniretic (moexipril/hydrochlorothiazide) – **PA**;  
see Table 18, p. 52  
Unithroid # (levothyroxine)  
Univasc # (moexipril) – see Table 18, p. 52  
unoprostone  
urea<sup>o</sup>  
urea/sodium propionate/methionine/cystine/  
inositol  
Urecholine (bethanechol)  
Urex # (methenamine)  
Urimax (methenamine/hyoscyamine/methylene  
blue)  
Urised (methenamine/benzoic acid/atropine/  
hyoscyamine/methylene blue)  
Urispas (flavoxate)  
Urocit-K (potassium citrate)  
Uroquid-Acid No. 2 (methenamine/sodium  
biphosphate)  
Uroxatral (alfuzosin) – **PA**; see Table 19, p. 53  
URSO (ursodiol)  
ursodiol  
Usept (methenamine/benzoic acid/atropine/  
hyoscyamine/phenylsalicylate/methylene blue)

## V

Vagifem (estradiol)  
valacyclovir  
Valcyte (valganciclovir)  
valdecocix – **PA < 60 years**; see Table 11, p. 45  
valganciclovir  
Valisone # (betamethasone) – see Table 16,  
p. 50  
valproate – see Table 20, p. 54  
valproic acid – see Table 20, p. 54  
valsartan – **PA**; see Table 18, p. 52  
valsartan/hydrochlorothiazide – **PA**; see  
Table 18, p. 52  
Valtrex (valacyclovir)  
Vanceril (beclomethasone), inhaler – see  
Table 23, p. 57  
Vancocin # (vancomycin)  
Vancoled # (vancomycin)  
vancomycin  
Vanoxide-HC (benzoyl peroxide/hydrocortisone)

Vantin (cefepodoxime)  
vardenafil – **PA**; see Table 6, p. 40  
varicella-zoster immune globulin IM, human – see  
Table 1, p. 35  
Vascor (bepridil) – **PA**; see Table 22, p. 56  
Vaseretic # (enalapril/hydrochlorothiazide) – see  
Table 18, p. 52  
Vasocidin # (sulfacetamide/prednisolone)  
vasopressin  
Vasotec # (enalapril) – see Table 18, p. 52  
Veetids # (penicillin V)  
Velcade (bortezomib)  
Velivet (ethinyl estradiol/desogestrel)  
venlafaxine – **PA**; see Table 17, p. 51  
venlafaxine extended-release – **PA**; see Table 17,  
p. 51  
Venofer (iron sucrose)  
Venoglobulin-I (immune globulin IV, human) – **PA**;  
see Table 1, p. 35  
Venoglobulin-S (immune globulin IV, human) – **PA**;  
see Table 1, p. 35  
Ventolin # (albuterol)  
Ventolin, inhaler (albuterol) – **PA**; see Table 23,  
p. 57  
Ventolin HFA, inhaler (albuterol) – **PA**; see  
Table 23, p. 57  
Vepesid # (etoposide)  
verapamil – see Table 22, p. 56  
Verelan # (verapamil) – see Table 22, p. 56  
Vermox # (mebendazole)  
Versed # (midazolam)  
verteporfin  
Vesanoid (tretinoin) – see Table 10, p. 44  
Vexol (rimexolone)  
Viadur (leuprolide) – **PA**; see Table 2, p. 36  
Viagra (sildenafil) – **PA**; see Table 6, p. 40  
Vibramycin # (doxycycline)  
Vicodin # (hydrocodone/acetaminophen) – see  
Table 8, p. 42  
Vicoprofen # (hydrocodone/ibuprofen)  
vidarabine  
Vidaza (azacitidine)  
Videx (didanosine)  
vinblastine  
vincristine  
vinorelbine  
Viokase (amylase/lipase/protease)  
Vira-A (vidarabine)

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## Alphabetic List (cont.)

Viracept (nelfinavir)  
Viramune (nevirapine)  
Viread (tenofovir)  
Viroptic # (trifluridine)  
Visicol (sodium phosphate)  
Visken # (pindolol) – see Table 21, p. 55  
Vistaril # (hydroxyzine) – see Table 12, p. 46  
Vistide (cidofovir)  
Visudyne (verteporfin)  
vitamin A \* (retinol)  
vitamin B<sub>1</sub> \* (thiamine)  
vitamin B<sub>2</sub> \* (riboflavin)  
vitamin B<sub>3</sub> \* (niacin)  
vitamin B<sub>6</sub> \* (pyridoxine)  
vitamin B<sub>12</sub> \* (cyanocobalamin)  
vitamin B complex \*  
vitamin C \*  
vitamin D \*  
vitamin D/dihydrotachysterol/ergocalciferol  
vitamins, multiple \*  
vitamins, multiple/minerals \*  
vitamins, pediatric \*  
vitamins, prenatal \*  
Vivactil # (protriptyline) – see Table 17, p. 51  
Vivelle # (estradiol)  
Vivelle-Dot (estradiol)  
Vivotif Berna Vaccine (typhoid vaccine)  
Volmax (albuterol)  
Voltaren # (diclofenac) – see Table 11, p. 45  
Vosol # (acetic acid)  
Vytone (iodoquinol/hydrocortisone)  
Vytorin (ezetimibe/simvastatin) – **PA**; see Table 13, p. 47

## W

warfarin  
water for inhalation \*  
Welchol (colesevelam)  
Wellbutrin # (bupropion) – see Table 17, p. 51  
Wellbutrin SR # (bupropion sustained-release) – see Table 17, p. 51  
Wellbutrin XL (bupropion extended-release) – **PA**; see Table 17, p. 50  
Westcort # (hydrocortisone) – see Table 16, p. 50  
WinRho SDF (Rho(D) immune globulin IV, human) – see Table 1, p. 35

Winstrol (stanozolol)  
witch hazel \*  
Wycillin (penicillin G)

## X

Xalatan (latanoprost)  
Xanax # (alprazolam)  
Xanax XR (alprazolam extended-release) – **PA**  
Xeloda (capecitabine)  
Xerac AC (aluminum chloride)  
Xifaxan (rifaximin)  
Xodol (hydrocodone/acetaminophen) – **PA**; see Table 8, p. 42  
Xolair (omalizumab) – **PA**  
Xopenex (levalbuterol), inhalation solution – **PA**; see Table 23, p. 57  
Xylocaine # (lidocaine)  
Xylocaine-MPF # (lidocaine)

## Y

Yasmin (ethinyl estradiol/drospirenone)

## Z

Zaditor (ketotifen)  
zafirlukast – **PA > 16 years**  
zalcitabine  
zaleplon – **PA > 10 units/month**; see Table 15, p. 49  
Zanaflex # (tizanidine) – see Table 7, p. 41  
zanamivir – **PA > 20 units/month**  
Zantac # (ranitidine \*) – see Table 3, p. 37  
Zantac EFFERdose (ranitidine, effervescent tablet) – **PA**; see Table 3, p. 37  
Zarontin # (ethosuximide) – see Table 20, p. 54  
Zaroxolyn # (metolazone)  
Zavesca (miglustat)  
Z-Clinz (clindamycin) – **PA**  
Zebeta # (bisoprolol) – see Table 21, p. 55  
Zebutal (butalbital/acetaminophen/caffeine)  
Zegerid (omeprazole) – **PA** – see Table 21, p. 37  
Zelnorm (tegaserod) – **PA**  
Zemaira (alpha1-proteinase inhibitor-human)  
Zemplar (paricalcitol)  
Zenapax (daclizumab)  
Zerit (stavudine)

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## Alphabetic List (cont.)

Zestoretic # (lisinopril/hydrochlorothiazide) – see Table 18, p. 52  
Zestril # (lisinopril) – see Table 18, p. 52  
Zetia (ezetimibe) – **PA**  
Zevalin (ibritumomab) – **PA**  
Ziac # (bisoprolol/hydrochlorothiazide) – see Table 21, p. 55  
Ziagen (abacavir)  
zidovudine  
zileuton – **PA > 16 years**  
Zinacef # (cefuroxime)  
zinc oxide \*  
zinc sulfate  
Zincate (zinc sulfate)  
Ziox (papain/urea/chlorophyllin)  
ziprasidone – see Table 24, p. 58  
Zithromax (azithromycin)  
Zocor (simvastatin) – **PA**; see Table 13, p. 47  
Zocort HC (chloroxylenol/pramoxine/hydrocortisone)  
ZoDerm (benzoyl peroxide) – **PA**  
Zofran (ondansetron) 4mg, 8mg – **PA > 15 units/month**; see Table 27, p. 61  
Zofran (ondansetron) – **24mg – PA > 5 units/month**; see Table 27, p. 61  
Zofran (ondansetron) solution – **PA > 50 mL/month**; see Table 27, p. 61  
Zoladex (goserelin) – **PA**; see Table 2, p. 36  
zoledronic acid  
zolmitriptan, nasal spray – **PA**; see Table 14, p. 48  
zolmitriptan, orally disintegrating tablet – **PA > 6 units/month**; see Table 14, p. 48  
zolmitriptan, tablet – **PA > 6 units/month**; see Table 14, p. 48  
Zoloft (sertraline) – **PA**; see Table 17, p. 51  
zolpidem – **PA > 10 units/month**; see Table 15, p. 49  
Zometa (zoledronic acid)  
Zomig (zolmitriptan) – **PA > six units/month**; see Table 14, p. 48  
Zomig Nasal Spray (zolmitriptan) – **PA**; see Table 14, p. 47  
Zomig-ZMT (zolmitriptan, orally disintegrating tablet) – **PA > 6 units/month**; see Table 14, p. 48  
Zonalon (doxepin)  
Zone-A Forte (pramoxine/hydrocortisone)

Zonegran (zonisamide) – see Table 20, p. 54  
zonisamide – see Table 20, p. 54  
Zorbtive (somatropin) – **PA** – see Table 9, p. 43  
Zosyn (piperacillin/tazobactam)  
Zoto-HC (chloroxylenol/pramoxine/hydrocortisone)  
Zovia # (ethinyl estradiol/ethynodiol)  
Zovirax # (acyclovir)  
Zydane (hydrocodone/acetaminophen) – **PA**; see Table 8, p. 42  
Zyflo (zileuton) – **PA > 16 years**  
Zyloprim # (allopurinol)  
Zymar (gatifloxacin)  
Zyprexa (olanzapine) – see Table 24, p. 58  
Zyprexa IM (olanzapine injection) – **PA**  
Zyprexa Zydis (olanzapine, orally disintegrating tablets) – **PA**; see Table 24, p. 58  
Zyrtec (cetirizine) syrup – **PA > 12 years (except for LTC members)**; see Table 12, p. 46  
Zyrtec (cetirizine) tablets – **PA**; see Table 12, p. 46  
Zyrtec-D (cetirizine/pseudoephedrine) – **PA**; see Table 12, p. 46  
Zyvox (linezolid)

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**PA** Prior authorization is required. The prescriber must obtain prior authorization for the drug in order for the pharmacy to receive payment.

**#** This is a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

**\*** The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

**°** Prior-authorization status depends on the drug’s formulation.

Note: Any drug that does not appear on the List requires prior authorization.

## Therapeutic Class Tables

**Table 1 – Immune Globulins**

Drug Name	PA Status	Clinical Notes
cytomegalovirus immune globulin IV, human (CMV-IGIV) – CytoGam		<p><i>Rate and Route of Administration:</i></p> <ul style="list-style-type: none"> <li>administer only at rate, route, and concentration indicated for product; too rapid IV administration rate may lead to a precipitous drop in blood pressure, fluid overload, and a possible thrombotic event. Cautious use in patients with history of cardiovascular disease or thrombotic episodes.</li> </ul> <p><i>Renal Risk:</i></p> <ul style="list-style-type: none"> <li>IGIV (human) products have been associated with renal dysfunction, acute renal failure, and osmotic nephrosis. Risk factors include age &gt; 65 years, preexisting renal dysfunction, volume depletion, concurrent use of nephrotoxic drugs, diabetes, and sepsis. An additional risk appears to be associated with IGIV products containing sucrose as a stabilizer (Panglobulin, Gammar-P) when a total dose <math>\geq 400\text{mg/kg}</math> was given. Note that RespiGam also contains sucrose.</li> </ul> <p><i>Hypersensitivity Reactions:</i></p> <ul style="list-style-type: none"> <li>reportedly rare, however incidence may increase with use of large IM doses or repeated injections of immune globulins</li> </ul> <p><i>Live Virus Vaccines (measles, mumps, rubella, varicella):</i></p> <ul style="list-style-type: none"> <li>Antibodies present in immune globulin preparations may interfere with the immune response of live virus vaccines, especially when large doses of immunoglobulins are given. For many immune globulins, a live virus vaccine should not be administered within 3 months of immune globulin administration; a few immune globulins require an even longer period (5-11 months) before a live virus vaccine should be given; check individual manufacturer's recommendations for each product.</li> </ul>
hepatitis B immune globulin, human (HBIG) – BayHep B, H-BIG, HyperHep, Nabi-HB		
immune globulin IM, human (IGIM; gamma globulin; IgG) – immune serum globulin USP <sup>1</sup> , BayGam		
immune globulin IV, human (IGIV) – Carimune, Gamimmune N, Gammagard S/D, Gammar-P IV, Gamunex, Iveegam EN, Panglobulin, Polygam S/D, Sandoglobulin, Venoglobulin-I, Venoglobulin-S	PA	
antithymocyte globulin (equine) (ATG equine, LIG) – Atgam		
antithymocyte globulin (rabbit) (ATG rabbit) – Thymoglobulin		
rabies immune globulin IM, human (RIG) – BayRab, Imogam Rabies – HT		
Rho(D) immune globulin IM (Rho(D) IGIM) – BayRho-D Full Dose, Gamulin Rh, HypRho-D, RhoGAM		
Rho(D) immune globulin IM micro-dose (Rho(D) IG Micro-dose) – BayRho-D Mini Dose, HypRho-D Mini-Dose, MICRhoGAM, Mini-Gamulin Rh		
Rho(D) immune globulin IV, human (Rho(D) IGIV) – RhoPhylac, WinRho SDF		
respiratory syncytial virus immune globulin IV, human (RSV-IGIV) – RespiGam	PA	
tetanus immune globulin IM, human (TIG) – BayTet		
varicella-zoster immune globulin IM, human (VZIG) <sup>1</sup>		

<sup>1</sup> Product must be obtained through the Massachusetts Public Health Biologic Laboratories.

**Table 2 – Hormones – Gonadotropin-Releasing Hormone Analogs**

Drug Name	PA Status	Clinical Notes
Eligard (leuprolide)	PA	<p><i>For PA drugs, one of the following FDA-approved indications must be met. For unlabeled uses, approval will be considered based on current medical evidence.</i></p> <ul style="list-style-type: none"> <li>• breast cancer (advanced) – Zoladex</li> <li>• central precocious puberty – Lupron, Synarel</li> <li>• endometrial thinning – Zoladex</li> <li>• endometriosis – Lupron, Synarel, Zoladex</li> <li>• prostatic cancer (advanced) – Eligard, Lupron, Trelstar, Viadur, Zoladex</li> <li>• prostatic carcinoma (Stage B2-C) – Zoladex</li> <li>• uterine leiomyomata – Lupron</li> </ul> <p><i>Contraindications:</i></p> <ul style="list-style-type: none"> <li>• pregnancy and lactation – all products</li> <li>• undiagnosed, abnormal vaginal bleeding: leuprolide, Lupron, Viadur, Zoladex</li> </ul>
Lupron (leuprolide)	PA	
Synarel (nafarelin)	PA	
Trelstar (triptorelin)	PA	
Viadur (leuprolide)	PA	
Zoladex (goserelin)	PA	

**Table 3 – Gastrointestinal Drugs – Histamine H<sub>2</sub> Antagonists/Proton Pump Inhibitors**

**H<sub>2</sub> Antagonists**

Drug Name	PA Status	Clinical Notes
Axid (nizatidine)	PA	<i>Optimize Dosing Regimen:</i> <ul style="list-style-type: none"> <li>For duodenal or gastric ulcer treatment, administer total daily dose between evening meal and bedtime – ulcer healing is directly proportional to degree of nocturnal acid reduction.</li> </ul>
nizatidine (generic)	PA	
Pepcid # (famotidine *)		
Tagamet # (cimetidine *)		
Zantac # (ranitidine *)		
Zantac EFFERdose (ranitidine, effervescent tablet)	PA	<i>Duration of Therapy:</i> <ul style="list-style-type: none"> <li>duodenal ulcer (DU) – 4 weeks</li> <li>gastric ulcer (GU) – 8 weeks</li> </ul>

**Proton Pump Inhibitors (PPIs)**

Drug Name	PA Status	Clinical Notes
Aciphex (rabeprazole)	PA	<i>Optimize Dosing Regimen:</i> <ul style="list-style-type: none"> <li>For maximum efficacy, a PPI must be taken in a fasting state, just before or with breakfast. In general, for patients on PPIs it is not necessary to prescribe other antisecretory agents (e.g., H<sub>2</sub> antagonists, prostaglandins). If an antisecretory agent is prescribed with a PPI, the PPI should not be taken within 6 hours of the H<sub>2</sub> antagonist or prostaglandin. PPIs should not be taken on an “as needed” basis.</li> </ul> <i>QD Dosing versus BID Dosing:</i> <ul style="list-style-type: none"> <li>QD dosing is adequate for most individuals except for H. pylori treatment (PPI is BID for 1<sup>st</sup> two weeks of therapy). For pathological hypersecretory conditions, such as ZE Syndrome, a BID PPI regimen may be needed for high total daily doses. When/if a second dose is prescribed, it should be given just before the evening meal.</li> </ul> <i>Apparent PPI Non-responder:</i> <ul style="list-style-type: none"> <li>Careful history should be obtained to ensure appropriate timing of drug administration and no significant drug interactions (see above), before prescribing a second dose or switching to another PPI.</li> </ul> <i>Duration of Therapy:</i> <ul style="list-style-type: none"> <li>duodenal ulcer (DU) – 4 weeks (QD dosing)</li> <li>gastric ulcer (GU) – 8 weeks (QD dosing)</li> <li>H. pylori – 2 weeks (BID dosing) + 2 more weeks if DU using QD dosing and 6 more weeks if GU using QD dosing</li> <li>acute symptomatic GERD – 4-8 weeks (QD dosing)</li> </ul> <i>NG Tube Administration:</i> <p>Prevacid (lansoprazole) capsules can be opened and the intact granules mixed with 40 ml of apple juice and then administered through the NG tube. After administration, flush NG tube with additional apple juice. Prevacid suspension is not recommended for NG tube administration. It is a viscous liquid, and will thicken over time.</p> <i>Tablet/Capsule Administration:</i> <p>PPI tablets or the contents of PPI capsules should not be chewed, split, or crushed. For patients who have difficulty swallowing PPI capsules, the capsule can be opened and the intact granules can be sprinkled on applesauce. See specific product information for further information on liquids and foods compatible with capsule contents.</p>
Nexium (esomeprazole)	PA	
omeprazole (generic)	PA	
Prevacid (lansoprazole) capsules	PA > 16 years	
Prevacid IV (lansoprazole)	PA	
Prevacid SoluTab (lansoprazole, orally disintegrating tablet)	PA > 16 years	
Prevacid (lansoprazole) suspension	PA > 16 years (except for LTC members)	
Prilosec (omeprazole)	PA	
Protonix (pantoprazole)		
Zegerid (omeprazole)	PA	

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**Table 4 – Hematologic Agents – Hematopoietic Agents**

Drug Name	PA Status	Clinical Notes
Colony-Stimulating Factors		For PA drugs, an FDA-approved indication must be met. For unlabeled uses, approval will be considered based on current medical evidence.
Leukine (sargramostim; GM-CSF)	PA	
Neulasta (pegfilgrastim)	PA	
Neupogen (filgrastim; G-CSF)	PA	
Interleukins		Monitoring: <ul style="list-style-type: none"><li>colony-stimulating factors (G-CSF, GM-CSF) – Certain drugs, such as corticosteroids and lithium may potentiate the myeloproliferative effects of colony-stimulating factors; GM-CSF: fluid retention, occasional transient supraventricular arrhythmias, and dyspnea may occur – use cautiously in patients with cardiac or pulmonary disease.</li><li>erythropoietin – Evaluate iron status before and during therapy. Transferrin saturation should be at least 20% and serum ferritin at least 100 ng/ml. Most patients will eventually require supplemental iron.</li><li>oprelvekin – Fluid retention will occur. Use cautiously in patients with CHF or preexisting fluid collections (e.g., ascites, pericardial or pleural effusions).</li></ul>
Neumega (oprelvekin; IL-11)	PA	
Recombinant Human Erythropoietin		
Aranesp (darbepoetin alfa)	PA	
Epogen (epoetin alfa; EPO)	PA	
Procrit (epoetin alfa; EPO)	PA	

**Table 5 – Immunologic Agents – Immunomodulators**

Drug Name	PA Status	Clinical Notes
Actimmune (interferon gamma-1b)		<p><i>For PA drugs, one of the following FDA-approved indications must be met. For unlabeled uses, approval will be considered based on current medical evidence.</i></p> <ul style="list-style-type: none"> <li>• AIDS-related Kaposi's sarcoma – Intron A, Roferon-A</li> <li>• Chronic granulomatous disease – Actimmune</li> <li>• CML – Roferon-A</li> <li>• Condylomata acuminata – Alferon N, Intron A</li> <li>• Crohn's disease – Remicade</li> <li>• Erythema nodosum leprosum – Thalomid</li> <li>• Follicular lymphoma – Intron A</li> <li>• Hairy cell leukemia – Intron A, Roferon-A</li> <li>• Hepatitis B (chronic) – Intron A</li> <li>• Hepatitis C (chronic) – Infergen, Intron A, Pegasys, PEG-Intron, Rebetrone</li> <li>• Malignant melanoma – Intron A</li> <li>• Multiple sclerosis – Avonex, Betaseron, Novantrone, Rebif</li> <li>• Osteopetrosis – Actimmune</li> <li>• Psoriasis, severe – Amevive, Enbrel, Raptiva</li> <li>• Psoriatic arthritis – Enbrel</li> <li>• Rheumatoid arthritis, severe – Enbrel, Humira, Kineret, Remicade</li> <li>• Rheumatoid arthritis, juvenile – Enbrel</li> </ul> <p><i>Alfa interferons Precautions:</i></p> <ul style="list-style-type: none"> <li>• Life-threatening or fatal neuropsychiatric, autoimmune, ischemic, and infectious disorders may be caused or aggravated by alfa interferons. Monitor patients closely with periodic clinical and laboratory evaluations. See manufacturers' information for full details.</li> </ul>
Alferon N (interferon alfa-n3, human leukocyte derived)		
Amevive (alefacept)	PA	
Avonex (interferon beta-1a)		
Betaseron (interferon beta-1b)		
Enbrel (etanercept)	PA	
Humira (adalimumab)	PA	
Infergen (interferon alfacon-1)		
Intron A (interferon alfa-2b; IFN-alfa2; rIFN-α2; α-2-interferon)		
Kineret (anakinra)	PA	
Novantrone (mitoxantrone)		
Pegasys (peginterferon alfa-2a)	PA > 4 doses/month	
PEG-Intron (peginterferon alfa-2b)	PA > 4 doses/month	
Raptiva (efalizumab)	PA	
Rebetrone (interferon alfa-2b/ribavirin)	PA	
Rebif (interferon beta-1a)		
Remicade (infliximab)	PA	
Roferon-A (interferon alfa-2a; rIFN-A; IFLrA)		
Thalomid (thalidomide)	S.T.E.P.S. (restricted drug distribution program; only prescribers and pharmacists registered with this program may prescribe and dispense the drug)	

**Table 6 – Impotence Agents**

Drug Name	PA Status	Clinical Notes
Caverject (alprostadil, prostaglandin E <sub>1</sub> ; PE <sub>1</sub> )	PA	<ul style="list-style-type: none"> <li>MassHealth does not pay for any drug used to promote male or female fertility. MassHealth does not pay for medications used to treat male or female sexual dysfunction, without prior authorization.</li> <li>Sildenafil, tadalafil, and vardenafil may potentiate the hypotensive effects of nitrates, which in any form are contraindicated with use of sildenafil, tadalafil, and vardenafil.</li> <li>Sildenafil, tadalafil, and vardenafil are metabolized by cytochrome P450 enzymes 3A4 (major route) and 2C9 (minor route); use sildenafil, tadalafil, and vardenafil cautiously with 3A4 inhibitors such as ketoconazole, erythromycin, or cimetidine.</li> <li>Sildenafil, tadalafil, and vardenafil may potentiate the hypotensive effects of alpha blockers. Concomitant use may be contraindicated or require dose adjustments. Consult the manufacturer's literature for specific recommendations.</li> </ul>
Cialis (tadalafil)	PA	
Edex (alprostadil, prostaglandin E <sub>1</sub> ; PE <sub>1</sub> )	PA	
Levitra (vardenafil)	PA	
Muse (alprostadil, prostaglandin E <sub>1</sub> ; PE <sub>1</sub> )	PA	
Viagra (sildenafil)	PA	

**Table 7 – Muscle Relaxants – Centrally Acting**

Drug Name	PA Status	Clinical Notes
Banflex (orphenadrine)		<p><i>PA for Lioresal Intrathecal:</i></p> <p>Use for spasticity of spinal cord origin (FDA-approved indication) or, in children for reducing spasticity in cerebral palsy (unlabeled use). Other unlabeled uses will be considered based on current medical evidence.</p> <p><i>Precautions:</i></p> <ul style="list-style-type: none"> <li>• All agents within this class may cause drowsiness and dizziness. Patients should be advised of this and to avoid alcohol and other CNS depressants.</li> <li>• anticholinergic effects – baclofen, cyclobenzaprine, orphenadrine, tizanidine</li> <li>• cyclobenzaprine – structurally related to tricyclic antidepressants (TCAs); consider potential for similar adverse effects and drug interactions as with TCAs</li> <li>• tizanidine – an <math>\alpha_2</math> agonist structurally related to clonidine; may cause hypotension; hepatocellular injury reported — monitor LFTs</li> </ul> <p><i>Urine Discoloration:</i></p> <ul style="list-style-type: none"> <li>• orange or red-purple: chlorzoxazone</li> <li>• brown, black, or green: methocarbamol</li> </ul>
diazepam		
Flexeril # (cyclobenzaprine)		
Flexoject (orphenadrine)		
Flexon (orphenadrine)		
Lioresal Intrathecal (baclofen)	PA	
Lioresal # (baclofen)		
Maolate (chlorphenesin)		
Norflex # (orphenadrine)		
Norgesic # (orphenadrine/aspirin/caffeine)		
Parafon Forte DSC # (chlorzoxazone)		
Remular-S # (chlorzoxazone)		
Robaxin # (methocarbamol)		
Skelaxin (metaxalone)		
Soma # (carisoprodol)		
Zanaflex # (tizanidine)		

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Table 8 – Narcotic Agonist Analgesics

Drug Name	PA Status	Clinical Notes
<b>Diphenylheptanes</b>		<i>Allergy:</i> <ul style="list-style-type: none"><li>• True systemic narcotic allergy, such as a generalized rash, or angioedema, is unusual. A local, itchy wheal formation at the site of narcotic injection, generalized pruritus (no rash) or flushing may occur, and is due to histamine release. Meperidine is less likely to release histamine than morphine or other phenanthrenes; histamine release is not associated with fentanyl or methadone.</li></ul>
methadone (Dolophine #, Methadose #)	PA > 120 mg/day	
methadone powder	PA	
propoxyphene (Darvon #)		
propoxyphene napsylate (Darvon N)		
propoxyphene napsylate/acetaminophen (Darvocet-N #)		
<b>Phenanthrenes</b>		<i>Cross-Hypersensitivity:</i> <ul style="list-style-type: none"><li>• Systemic allergy manifestations, such as a generalized rash, or angioedema, although uncommon, are most likely to occur with natural opium alkaloids, such as morphine and codeine. If systemic allergy to morphine or codeine, a narcotic from a different chemical classification (i.e., diphenylheptanes, phenylpiperidines) should be selected. Ultram (tramadol) is structurally unrelated to opiates; however, the manufacturer states that it should not be used if there is previous hypersensitivity reaction to opiates.</li></ul> <i>Renal Dysfunction:</i> <ul style="list-style-type: none"><li>• Accumulation of certain narcotics in patients with significant renal dysfunction can lead to excess sedation, respiratory depression, delirium, myoclonus, or seizures.<ul style="list-style-type: none"><li>- avoid use: meperidine</li><li>- cautious use: codeine, hydrocodone, morphine</li></ul></li></ul> <i>Constipation:</i> <ul style="list-style-type: none"><li>• Common adverse effect with chronic narcotic use; prescribe stool softener +/- laxative with narcotic.</li></ul> <i>Acetaminophen Hepatotoxicity:</i> <ul style="list-style-type: none"><li>• Acetaminophen has been associated with severe hepatotoxicity following acute and chronic ingestion.</li><li>• Maximum recommended dose of acetaminophen for adults is four grams/day.</li><li>• Be sure to consider and ask about all potential sources of acetaminophen (e.g., OTC, combination analgesics) when determining daily acetaminophen dose.</li><li>• Risk may increase with concurrent alcohol use, underlying liver disease, and/or the fasting state.</li></ul>
codeine	PA > 360 mg/day	
codeine/acetaminophen (Tylenol/codeine #)		
codeine/aspirin (generics)		
hydrocodone/acetaminophen (Anexsia #, Hydrocet #, Lorcet #, Lortab #, Norco #, Vicodin #)		
hydrocodone/acetaminophen (Maxidone, Zydone, Xodol)	PA	
hydrocodone/ibuprofen (Vicoprofen #)		
hydrocodone/ibuprofen (Reprexain)	PA	
hydromorphone (Dilaudid #)		
hydromorphone extended-release (Palladone)	PA	
hydromorphone powder	PA	
levorphanol (Levo-Dromoran #)	PA > 32 mg/day	
levorphanol powder	PA	
morphine injection (Astramorph PF, Duramorph, Infumorph)		
morphine oral immediate release (MS/L, MSIR, OMS, Roxanol, Roxanol-T)	PA > 360 mg/day	
morphine controlled release (MS Contin #, Oramorph SR)	PA > 360 mg/day	
morphine extended-release (Avinza)	PA	
morphine powder	PA	
morphine sustained release (Kadian)	PA > 360 mg/day	
morphine suppositories (MS/S, RMS, Roxanol)		
oxycodone immediate release (Endocodone, Oxydose, OxyFAST, Oxy IR, Roxicodone)	PA > 240 mg/day	
oxycodone/acetaminophen (Endocet, Roxicet, Tylox #)		
oxycodone/acetaminophen (Percocet)	PA	
oxycodone/aspirin (Endodan, Percodan #, Roxiprin)		
oxycodone powder	PA	
oxycodone controlled release (OxyContin)	PA	
oxymorphone (Numorphan)		
<b>Phenylpiperidines</b>		
fentanyl injection		
fentanyl transdermal system (Duragesic)	PA	
fentanyl transmucosal system (Actiq)	PA	
meperidine (Demerol #)	PA > 750 mg/day	

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**Table 9 – Growth Hormones**

Drug Name	PA Status	Clinical Notes
somatrem – Protropin	PA	<p><i>For PA drugs, one of the following FDA-approved indications must be met. For unlabeled uses, approval will be considered based on current medical evidence.</i></p> <ul style="list-style-type: none"> <li>• growth failure in children due to lack of endogenous growth hormone secretion – all products except Serostim</li> <li>• growth failure in children due to Prader-Willi Syndrome – Genotropin</li> <li>• growth failure in children associated with chronic renal insufficiency – Nutropin, Nutropin AQ</li> <li>• short stature associated with Turner Syndrome – Nutropin, Nutropin AQ, Humatrope</li> <li>• growth hormone deficiency in adults – Genotropin, Humatrope, Nutropin, Nutropin AQ</li> <li>• AIDS wasting or cachexia – Serostim</li> <li>• Short Bowel Syndrome in patients receiving specialized nutritional support – Zorbtive</li> </ul> <p><i>Contraindications:</i></p> <ul style="list-style-type: none"> <li>• active malignancy</li> <li>• growth promotion in children with fused epiphyses</li> </ul>
somatropin – Genotropin Humatrope Norditropin Nutropin, Nutropin AQ Saizen Serostim Zorbtive	PA	

**Table 10 – Dermatologic Agents – Retinoids**

Drug Name	PA Status	Clinical Notes
Accutane # (isotretinoin; 13-cis-Retinoic Acid)		<p><i>For PA drugs</i>, one of the following FDA-approved indications must be met. For unlabeled uses, approval will be considered based on current medical evidence.</p> <ul style="list-style-type: none"> <li>acne vulgaris – Altinac, Avita, Differin, Retin-A, Tazorac</li> <li>Kaposi’s sarcoma cutaneous lesions – Panretin</li> <li>psoriasis (stable) – Tazorac</li> </ul> <p><i>Contraindicated in Pregnancy:</i></p> <ul style="list-style-type: none"> <li>Accutane, Soriatane, Tazorac, and Tegison</li> <li>Accutane – Prescribers must comply with the manufacturer’s S.M.A.R.T. program: System to Manage Accutane Related Teratogenicity (see manufacturer’s product information for full details).</li> </ul> <p><i>Photosensitivity Reactions:</i></p> <ul style="list-style-type: none"> <li>Minimize exposure to ultraviolet light or sunlight.</li> <li>other drugs that may also increase sensitivity to sun: quinolones, sulfonamides, thiazide diuretics, phenothiazines</li> </ul>
Avita <sup>1</sup> # (tretinoin; trans-retinoic acid; vitamin A acid) <sup>1</sup>	PA > 25 years	
Differin <sup>1</sup> (adapalene)	PA > 25 years	
Panretin <sup>1</sup> (alitretinoin)	PA	
Retin-A <sup>1</sup> # (tretinoin; trans-retinoic acid; vitamin A acid) <sup>1</sup>	PA > 25 years	
Soriatane (acitretin)		
Tazorac <sup>1</sup> (tazarotene)	PA > 25 years	
Tegison (etretinate)		
Vesanoid <sup>2</sup> (tretinoin)		

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<sup>1</sup> topical products

<sup>2</sup> indicated for acute promyelocytic leukemia

Table 11 – Nonsteroidal Anti-inflammatory Drugs

## Non-Selective NSAIDs

Non-Selective NSAIDs		Clinical Notes
Drug Name	PA Status	<p><i>Risk factors for NSAID-related GI toxicity:</i></p> <ul style="list-style-type: none"><li>• age &gt; 60 years, history of gastric or duodenal ulcer, history of GI bleed, perforation or obstruction, concurrent use of anticoagulants, aspirin (including low doses for cardiovascular prophylaxis), corticosteroids, high daily NSAID doses</li></ul> <p><i>To avoid or minimize GI toxicity:</i></p> <ul style="list-style-type: none"><li>• Lowest effective dose should be prescribed for the shortest possible duration.</li><li>• GI toxicity may be lower with ibuprofen, naproxen, ketoprofen, diclofenac, and higher with indomethacin, flurbiprofen, and piroxicam.</li></ul> <p><i>If risk factors are present for NSAID-related GI toxicity as above, consider:</i></p> <ul style="list-style-type: none"><li>• etodolac, nabumetone and meloxicam, all of which are preferential COX-2 inhibitors; however, with higher doses of etodolac and nabumetone, preferential inhibition of COX-2 is diminished.</li><li>• highly selective COX-2 inhibitor (see table below).</li></ul> <p><i>Risk factors for NSAID-related renal toxicity:</i></p> <ul style="list-style-type: none"><li>• preexisting renal disease, severe CHF liver disease, or diuretic use</li></ul>
Acetic Acid Derivatives		
Clinoril # (sulindac)		
Indocin # (indomethacin)		
Lodine # (etodolac)		
Relafen # (nabumetone)		
Tolectin # (tolmetin)		
Anthranilic Acid Derivatives		
meclofenamate		
Ponstel (mefenamic acid)	PA	
Enolic Acid Derivatives		
Feldene # (piroxicam)		
Mobic (meloxicam)	PA < 60 years	
Phenylacetic Acid Derivatives		
Arthrotec (diclofenac/ misoprostol)	PA < 60 years	
Voltaren # (diclofenac)		
Propionic Acid Derivatives		
Anaprox # (naproxen *)		
Ansaid # (flurbiprofen)		
Daypro # (oxaprozin)		
Motrin # (ibuprofen *)		
Nalfon # (fenoprofen)		
Naprosyn # (naproxen *)		
Prevacid NapraPAC (lansoprazole/naproxen)	PA	
Orudis # (ketoprofen *)		
Oruvail # (ketoprofen *)		
Toradol # (ketorolac)	PA > 20 units/month	
Salicylic Acid Derivative		
Dolobid # (diflunisal)		

## COX-2 (Highly Selective) NSAIDs

Drug Name	PA Status	Clinical Notes
Bextra (valdecoxib)	PA < 60 years	<p><i>Osteoarthritis(OA)/Rheumatoid Arthritis (RA) Dosing:</i></p> <ul style="list-style-type: none"> <li>Bextra: OA: 10 mg QD; RA: 10 mg QD</li> <li>Celebrex: OA: 200 mg QD or 100 mg BID; RA: 100-200 mg BID</li> </ul> <p><i>Sulfonamide Allergy:</i></p> <ul style="list-style-type: none"> <li>Celebrex and Bextra are both sulfonamide derivatives. The labeling for Celebrex and Bextra state that use is contraindicated in sulfonamide-allergic patients.</li> </ul>
Celebrex (celecoxib) PA < 60 years	PA < 60 years	

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\* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

Table 12 – Antihistamines

**First Generation (Non-Selective) Antihistamines**

Drug Name <sup>1</sup>	PA Status	Sedative Effect <sup>2</sup>	Antihistamine Effect <sup>2</sup>	Anticholinergic Effect <sup>2</sup>
<b>Alkylamines</b>				
brompheniramine *		1+	3+	2+
Chlor-Trimeton # (chlorpheniramine *)		1+	2+	2+
Polaramine # (dexchlorpheniramine)		1+	3+	2+
<b>Ethanolamines</b>				
Benadryl # (diphenhydramine *)		3+	1+/2+	3+
carbinoxamine		1+	1+/2+	1+
Tavist # (clemastine)		2+	1+/2+	3+
<b>Ethylenediamine</b>				
PBZ # (tripelennamine)		2+	1+/2+	+/-
<b>Phenothiazine</b>				
Phenergan # (promethazine)		3+	3+	3+
<b>Piperazines</b>				
Atarax # (hydroxyzine)		3+	2+/3+	2+
Vistaril # (hydroxyzine)		3+	2+/3+	2+
<b>Piperidines</b>				
Optimine (azatadine)	PA	2+	2+	2+
Periactin # (cyproheptadine)		1+	2+	2+
Trinalin Repetabs (azatadine/pseudoephedrine)	PA	2+	2+	2+

**Second Generation (Peripherally Selective) Antihistamines**

Drug Name <sup>1</sup>	PA Status	Sedative Effect <sup>2</sup>	Antihistamine Effect <sup>2</sup>	Anticholinergic Effect <sup>2</sup>
Alkylamine				
Semprex-D (acrivastine/pseudoephedrine)	PA	+/-	2+/3+	+/-
Phthalazinone				
Astelin (azelastine)	PA > 1 inhaler/month	+/-	2+/3+	+/-
Piperazines				
Zyrtec (cetirizine), syrup	PA > 12 years (except for LTC members)	+/-	2+/3+	+/-
Zyrtec (cetirizine), tablets	PA			
Zyrtec-D (cetirizine/pseudoephedrine)	PA			
Piperidines				
Allegra (fexofenadine)	PA	+/-	2+/3+	+/-
Allegra-D (fexofenadine/pseudoephedrine)	PA			
Clarinet (desloratadine)	PA	+/-	3+	+/-
loratadine (generics)		+/-	2+/3+	+/-

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\* The generic OTC and, if any, generic prescription versions of the drug are payable under MassHealth without prior authorization.

<sup>1</sup> Combinations of antihistamines and decongestants (for example, brompheniramine/pseudoephedrine) are payable under MassHealth, but are not listed in the antihistamine table unless PA is required for the combination.

<sup>2</sup> low to none = +/-; low = 1+; moderate = 2+; high = 3+ (Note: Pseudoephedrine, a sympathomimetic that may cause mild CNS stimulation, may lessen the sedative effect of antihistamines. Occasionally however, pseudoephedrine may also cause drowsiness. The antihistaminic and anticholinergic effects of antihistamines are not likely to be affected by the addition of pseudoephedrine.)

**Table 13 – Statins**

**(All Statins are subject to a quantity limit of 30 units/month.)**

Drug Name	PA Status	Clinical Notes
Advicor (lovastatin/niacin)	PA	<p>The NCEP ATP III guidelines can be found on the following website:  <a href="http://www.nhlbi.nih.gov/guidelines/cholesterol">www.nhlbi.nih.gov/guidelines/cholesterol</a></p> <p><i>Adverse Effects:</i></p> <ul style="list-style-type: none"> <li>• <i>Hepatotoxicity:</i>            Although the risk of liver toxicity is low, the risk may increase with dose increments. Liver function tests should be performed before and at 8 or 12 weeks, following therapy initiation, increase in dose and semiannually. Any increase in ALT, AST, or CPK of greater than 3 times ULN, dose reduction or withdrawal is recommended</li> <li>• <i>Myopathy:</i>            Severe myopathy has been reported and is dose-related. It can lead to myoglobinuria and acute renal failure. Risk factors for statin-induced myopathy are drug-drug interactions, hepatic or renal failure, acute infection, or hypothyroidism.</li> </ul>
Altocor (extended-release lovastatin)	PA	
Altoprev (extended-release lovastatin)	PA	
Caduet (amlodipine/atorvastatin)	PA	
Crestor (rosuvastatin)	PA > 30 units/month	
Lescol (fluvastatin)	PA > 30 units/month	
Lescol XL (fluvastatin extended-release)	PA > 30 units/month	
Lipitor (atorvastatin)	PA > 30 units/month	
lovastatin	PA > 30 units/month	
Mevacor (lovastatin)	PA	
Pravachol (pravastatin)	PA	
Pravigard PAC (pravastatin/aspirin)	PA	
Vytorin (ezetimibe/simvastatin)	PA	
Zocor (simvastatin)	PA	

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**Table 14 – Triptans**

Drug Name	PA Status	Clinical Notes
Amerge (naratriptan) tablet	PA	<p><i>FDA-Approved Indications:</i></p> <ul style="list-style-type: none"> <li>acute treatment of migraine (all triptans)</li> <li>acute treatment of cluster headache episodes—Imitrex injection only</li> <li>Triptans are NOT intended for prophylactic therapy of migraines.</li> </ul> <p><i>General contraindications (consult prescribing information for specific information regarding individual agents):</i></p> <ul style="list-style-type: none"> <li>history, presence, symptoms, or signs of ischemic heart disease (e.g., angina, MI, stroke, TIA), coronary artery vasospasm, or other significant underlying cardiovascular disease</li> <li>uncontrolled hypertension</li> <li>concurrent use or use within 24 hours of ergotamine-containing products or ergot-type medications (e.g., dihydroergotamine, methysergide)</li> <li>concurrent use with MAO inhibitor therapy or within two weeks of MAO inhibitor discontinuation</li> <li>use within 24 hours of treatment with another triptan</li> <li>management of hemiplegic or basilar migraine hypersensitivity to the product or any of its ingredients</li> </ul> <p><i>Do not exceed the maximum recommended dose per 24-hour period.</i></p> <p><i>Orally Disintegrating Tablets:</i></p> <ul style="list-style-type: none"> <li>Place tablet on tongue, where it will be dissolved and swallowed with saliva.</li> <li>Inform phenylketonurics that tablets contain phenylalanine.</li> </ul> <p><i>Migraine prophylaxis (e.g., amitriptyline, propranolol, timolol) may be considered for the following conditions:</i></p> <ul style="list-style-type: none"> <li>migraine occurs <math>\geq</math> twice monthly and produces disability lasting <math>\geq</math> three days per month</li> <li>contraindication to, or failure of, acute treatments</li> <li>abortive medications are used <math>&gt;</math> twice per week</li> <li>other severe migraine conditions</li> </ul>
Axert (almotriptan) tablet	PA > six units/month	
Frova (frovatriptan) tablet	PA	
Imitrex (sumatriptan), injection	PA > 2 units (4 injections)/month	
Imitrex (sumatriptan), nasal spray, tablet	PA	
Maxalt (rizatriptan) tablet	PA	
Maxalt-MLT (rizatriptan), orally disintegrating tablet	PA	
Relpax (eletriptan) tablet	PA	
Zomig Nasal Spray (zolmitriptan)	PA	
Zomig (zolmitriptan) tablet	PA > six units/month	
Zomig-ZMT (zolmitriptan), orally disintegrating tablet	PA > six units/month	

**Table 15 – Hypnotics**

Drug Name	PA Status	Duration of Action	Clinical Notes
Ambien (zolpidem)	PA > 10 units/month	short	<ul style="list-style-type: none"> <li>Hypnotics are primarily FDA-approved for transient or short-term treatment of insomnia.</li> <li>There is limited medical evidence on the safety and efficacy of prolonged use of hypnotics.</li> <li>Nonpharmacologic treatments, such as practicing good sleep hygiene, relaxation training, and cognitive therapy may be more effective than medications in some individuals.</li> <li>To avoid tolerance and dependence, use the lowest dose, intermittently, and for the shortest possible duration.</li> <li>Recommended hypnotic dosages are generally lower in the elderly.</li> </ul> <p>See “10 Tips for a Good Night’s Sleep” (<a href="http://www.mass.gov/druglist">www.mass.gov/druglist</a>).</p>
Dalmane # (flurazepam)	PA > 10 units/month	long	
Doral (quazepam)	PA	long	
Halcion # (triazolam)	PA > 10 units/month	short	
ProSom # (estazolam)	PA > 10 units/month	intermediate	
Restoril # (temazepam)	PA > 10 units/month	intermediate	
Sonata (zaleplon)	PA > 10 units/month	ultra-short	

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Table 16 – Topical Corticosteroids

Drug Name	PA Status	Clinical Notes
<b>I. Low Potency</b>		<b>Product Potency:</b> <ul style="list-style-type: none"><li>Relative potency of a product depends on the characteristics and concentration of the drug and the vehicle.</li><li>Generally, ointments and gels are more potent than creams or lotions; however, some products have been formulated to yield comparable potency.</li></ul> <b>Product Selection:</b> <ul style="list-style-type: none"><li>Selection of a specific corticosteroid, strength and vehicle depends on the nature, location, and extent of the skin condition, patient's age, and anticipated duration of treatment.</li><li>Use the least potent corticosteroid that would be effective.</li><li>Low potency agents are preferred for the face, intertriginous areas (e.g., groin, axilla), large areas, and children, to reduce the potential for side effects.</li><li>Reserve higher potency agents for areas and conditions resistant to treatment with milder agents.</li></ul> <b>Adverse Reactions:</b> <ul style="list-style-type: none"><li>Systemic absorption of topical corticosteroids has produced reversible HPA axis suppression, Cushing's syndrome, hyperglycemia, and glycosuria.</li><li>Conditions that augment systemic absorption include application of more potent steroids, use over large surface areas, prolonged use, addition of occlusive dressings, and patient's age.</li><li>Perform appropriate clinical and laboratory tests if a topical corticosteroid is used for long periods or over large areas of the body.</li><li>With chronic conditions, gradual discontinuation of therapy may reduce the chance of rebound.</li></ul>
alclometasone dipropionate 0.05% C, O (Aclovate)	PA	
alclometasone dipropionate 0.05% O (generics)		
desonide C, L, O 0.05% (DesOwen #)		
fluocinolone acetonide 0.01% C, S (Synalar #)		
fluocinolone acetonide 0.01% oil (Derma-Smoother/FS), shampoo (Capex)	PA	
hydrocortisone 0.5% C, L; 1% C, L, O, S; 2.5% C, L, O (Anusol-HC #, Hytone #, Texacort #)		
<b>II. Medium Potency</b>		
betamethasone dipropionate 0.05% L (generics)		
betamethasone dipropionate 0.05% L (Diprosone)	PA	
betamethasone valerate 0.12% A (Luxiq)	PA	
betamethasone valerate 0.1% C, L (Beta-Val #, Valisone #)		
clocortolone pivalate 0.1% C (Cloderm)	PA	
desoximetasone 0.05% C (Topicort LP #)		
fluocinolone acetonide 0.025% C, O (Synalar #)		
flurandrenolide 0.05% L (generics)		
flurandrenolide 0.025% C, O; 0.05% C, L, O, T (Cordran)	PA	
fluticasone propionate 0.05% C, 0.005% O (Cutivate #)		
hydrocortisone butyrate 0.1% C, O, S (Locoid)	PA	
hydrocortisone probutate 0.1% C (Pandel)	PA	
hydrocortisone valerate 0.2% C, O (Westcort #)		
mometasone furoate 0.1% O (generics)		
mometasone furoate 0.1% C, L, O (Elocon)	PA	
prednicarbate 0.1% C, O (Dermatop)	PA	
triamcinolone acetonide 0.025% C, L, O; 0.1% C, L, O; (Kenalog #, Aristocort #, Aristocort A #)		
<b>III. High Potency</b>		
amcinonide 0.1% C, L, O (Cyclocort #)		
augmented betamethasone, L (Diprolene)	PA	
augmented betamethasone, C (Diprolene AF #)		
betamethasone dipropionate 0.05% C, O (generics)		
betamethasone dipropionate 0.05% C, O; 0.1% A (Diprosone)	PA	
betamethasone dipropionate 0.05% G (Diprolene)		
betamethasone valerate 0.1% O (Beta-Val #, Valisone #)		
desoximetasone 0.05% G; 0.25% C, O (Topicort #)		
diflorasone diacetate 0.05% C (Psorcon #)		
fluocinonide 0.05% C, G, O, S (Lidex #)		
halcinonide 0.1% C, O, S (Halog, Halog-E)	PA	
triamcinolone acetonide 0.5% C, O (Aristocort #, Aristocort A # Kenalog#)		
<b>IV. Very High Potency</b>		
augmented betamethasone dipropionate 0.05% O (generics)		
augmented betamethasone dipropionate 0.05% O (Diprolene)	PA	
clobetasol propionate 0.05% C, G, O, S (Cormax#, Embeline #, Temovate #)		
clobetasol propionate 0.05% A (Olux)	PA	
diflorasone diacetate 0.05% O (Psorcon #)		
halobetasol propionate 0.05% C, O (Ultravate)	PA	

A=aerosol, C=cream, G=gel, L=lotion, O=ointment, S=solution

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Table 17 – Antidepressants

Drug Name	PA Status	Clinical Notes
<b>Selective Serotonin Reuptake Inhibitors (SSRI)</b>		<ul style="list-style-type: none"><li>In general, the elderly are more sensitive to side effects of medications – especially to sedation, orthostatic hypotension and anticholinergic symptoms. Because of changes in drug metabolism, older patients need lower doses of antidepressants to reach therapeutic effect. Thus the maxim, “Start low and go slow.”</li><li>MassHealth does not encourage the use of combination products and recommends that the active medications be prescribed individually.</li><li>There is no evidence to support the use of two SSRIs or an SSRI and venlafaxine concurrently. These combinations duplicate drug action, with increased side effects and little clinical benefit. PA is required when a patient has an overlap of 60 days or more in prescriptions of two SSRIs or an SSRI and venlafaxine.</li><li>Due to bupropion’s dose dependant risk of seizure (0.33-0.4% within recommended dosing limits) please dose accordingly. Bupropion immediate release (IR) should be dosed no greater than 150 mg per dose and 450 mg per day. Bupropion sustained release (SR) should be dosed no greater than 200 mg per dose and 400 mg per day. Bupropion extended-release (XL) requires PA. It should be dosed no greater than 450 mg a day as a single dose. Patients with seizure disorders, brain injuries, and eating disorders are at highest risk of seizures.</li><li>Brand name Serzone is no longer available due to reports of life-threatening hepatic failure resulting in death or transplant. Generic nefazodone is still available from various manufacturers.</li><li>Blood pressure should be monitored during venlafaxine therapy because it may cause a dose-related increase in diastolic blood pressure (reported in three-13% of patients).</li><li>Antidepressant discontinuation syndrome has been commonly reported with SSRIs and venlafaxine. Among the SSRIs, this is most commonly reported with paroxetine (whose half-life is short and there is no active metabolite), and reported least with fluoxetine (with a long half-life and an active, long-acting metabolite). Symptoms include dizziness, nausea, fatigue, lethargy, flu-like symptoms, anxiety, irritability, and insomnia. This often occurs one-three days after abruptly stopping the medication. The agents in question should be slowly tapered to avoid this syndrome.</li></ul>
citalopram		
citalopram (Celexa)	PA	
escitalopram (Lexapro)	PA	
fluoxetine (fluoxetine 20 mg capsule, fluoxetine 10 mg, Prozac #)		
fluoxetine (fluoxetine 20 mg tablet, fluoxetine 40 mg capsule, Prozac Weekly, Sarafem )	PA	
fluoxetine/olanzapine (Symbyax)	PA	
fluvoxamine (Luvox #)		
paroxetine hydrochloride (Paxil #)		
paroxetine mesylate (Pexeva)	PA	
paroxetine HCL controlled-release (Paxil CR)	PA	
sertraline (Zoloft)	PA	
<b>Norepinephrine/Dopamine Reuptake Inhibitors (NDRI)</b>		
bupropion (Wellbutrin #)		
bupropion extended-release tablets (Wellbutrin XL)	PA	
bupropion sustained-release (Wellbutrin SR #)		
<b>Serotonin Antagonist/ Reuptake Inhibitors (SARI)</b>		
nefazodone (Serzone #)		
trazodone (Desyrel #)		
<b>Serotonin/Norepinephrine Reuptake Inhibitors (SNRI)</b>		
duloxetine (Cymbalta)	PA	
venlafaxine (Effexor)	PA	
venlafaxine extended-release (Effexor)	PA	
<b>Monoamine Oxidase Inhibitors (MAOI)</b>		
phenelzine (Nardil)		
tranylcypromine (Parnate)		
<b>Noradrenergic and Specific Serotonergic Antidepressants (NaSSA)</b>		
mirtazapine (Remeron #)		
mirtazapine, orally disintegrating tablet (generics, Remeron Sol Tab)	PA	
<b>Tricyclic Antidepressants (TCA)</b>		
amitriptyline (Elavil #)		
amoxapine (generics)		
clomipramine (Anafranil #)		
desipramine (Norpramin #)		
doxepin (Sinequan #)		
imipramine (Tofranil #)		
maprotiline (generics)		
nortriptyline (Aventyl #, Pamelor #)		
protriptyline (Vivactil #)		
trimipramine (Surmontil)		
<b>Selective Serotonin Reuptake Inhibitor and Atypical Antipsychotic</b>		
fluoxetine/olanzepine (Symbvax)	PA	

*Monoamine Oxidase Inhibitors (MAOI):*

- Hypertensive crisis may occur when MAOI inhibitors are coadministered with some prescription and over-the-counter products, and foods, especially those high in tyramine.
- Serotonin syndrome can occur when MAOI are coadministered with other pro-serotonergic medications.
- Members should be counseled about dietary and medication restrictions and be given a list of foods and drugs to be avoided.

*See Pharmacy Program Antidepressant Initiative (www.mass.gov/druglist) for more information about PA requirements for antidepressants.*

*Monoamine Oxidase Inhibitors (MAOI):*

- Hypertensive crisis may occur when MAOI inhibitors are coadministered with some prescription and over-the-counter products, and foods, especially those high in tyramine.
- Serotonin syndrome can occur when MAOI are coadministered with other pro-serotonergic medications.
- Members should be counseled about dietary and medication restrictions and be given a list of foods and drugs to be avoided.

See Pharmacy Program Antidepressant Initiative ([www.mass.gov/druglist](http://www.mass.gov/druglist)) for more information about PA requirements for antidepressants.

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**Table 18 – Renin Angiotensin System Antagonists**

Drug Name	PA Status	Clinical Notes
<b>Angiotensin – Converting Enzyme (ACE) Inhibitors</b>		<p><i>Dose and administration:</i></p> <ul style="list-style-type: none"><li>Initial doses may need to be lower in the elderly, and in patients who are on a diuretic or are volume depleted.</li></ul> <p><i>Nonproductive dry cough:</i></p> <ul style="list-style-type: none"><li>Incidence is about 10-20% on an ACE inhibitor, but very uncommon in the angiotensin II receptor antagonists.</li><li>Cough usually resolves within 1-4 days after therapy is discontinued.</li></ul> <p><i>Adverse reactions:</i></p> <ul style="list-style-type: none"><li>Higher incidence of skin rash and dysgeusia with captopril, compared to other ACE inhibitors, has been attributed to its sulfhydryl group.</li><li>Risk factors for hyperkalemia may include renal insufficiency, diabetes, concomitant nonsteroidal anti-inflammatory drugs, potassium supplements, and/or potassium-sparing diuretics.</li><li>Angioneurotic edema is less likely to occur with angiotensin II receptor blockers than ACE inhibitors, but cross-reactivity has been reported.</li></ul> <p><i>Pregnancy:</i></p> <ul style="list-style-type: none"><li>May cause fetal or neonatal injury or death when used during the second or third trimester of pregnancy.</li><li>When pregnancy is detected, discontinue these drugs as soon as possible.</li></ul>
amlodipine/benazepril (Lotrel)	PA	
benazepril (Lotensin #)		
captopril (Capoten #)		
captopril/hydrochlorothiazide (Capozide #)		
enalapril (Vasotec #)		
enalapril/hydrochlorothiazide (Vaseretic #)		
enalapril/felodipine (Lexxel)	PA	
fosinopril (Monopril #)		
lisinopril (Prinivil #, Zestril #)		
lisinopril/hydrochlorothiazide (Prinzide #, Zestoretic #)		
moexipril (Univasc #)		
moexipril/hydrochlorothiazide (Uniretic)	PA	
perindopril (Aceon)	PA	
quinapril (Accupril)	PA	
quinapril/hydrochlorothiazide (Accuretic)	PA	
ramipril (Altace)	PA	
trandolapril (Mavik)	PA	
trandolapril/verapamil (Tarka)	PA	
<b>Angiotensin II Receptor Antagonists</b>		
candesartan (Atacand)	PA	
eprosartan (Teveten)	PA	
irbesartan (Avapro)	PA	
irbesartan/hydrochlorothiazide (Avalide)	PA	
losartan (Cozaar)	PA	
losartan/hydrochlorothiazide (Hyzaar)	PA	
olmesartan (Benicar)	PA	
telmisartan (Micardis)	PA	
valsartan (Diovan)	PA	
valsartan/hydrochlorothiazide (Diovan HCT)	PA	

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**Table 19 – Alpha-1 Adrenergic Blockers**

Drug Name	PA Status	Clinical Notes
alfuzosin (Uroxatral)	PA	<i>FDA-approved indications:</i> <ul style="list-style-type: none"> <li>Hypertension: doxazosin, prazosin, prazosin/polythiazide, terazosin</li> <li>Benign prostatic hyperplasia (BPH): alfuzosin, doxazosin, tamsulosin, terazosin</li> </ul> <i>Dose and administration:</i> <ul style="list-style-type: none"> <li>Doxazosin, prazosin, and terazosin: take first dose and subsequent first increased dose at bedtime to minimize lightheadedness and syncope.</li> <li>Titrate to therapeutic maintenance doses to minimize dizziness and orthostatic hypotension.</li> <li>If therapy is discontinued or interrupted for two or more days, reinstitute therapy cautiously.</li> </ul> <i>PSA levels:</i> <ul style="list-style-type: none"> <li>Alpha-1 adrenergic receptor antagonists do not affect PSA levels.</li> </ul>
doxazosin (Cardura #)		
prazosin (generics)		
prazosin/polythiazide (Minizide)		
tamsulosin (Flomax)	PA	
terazosin (Hytrin #)		

# This is a brand-name drug with FDA “A”-rated generic equivalents. Prior authorization is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A”-rated generic equivalent.

**Table 20 – Anticonvulsants**

Drug Name	PA Status	Clinical Notes
carbamazepine (Carbatrol, Epitol, Tegretol #)		For PA drugs, one of the following FDA-approved indications must be met.
clonazepam (Klonopin #)		
clonazepam, orally disintegrating tablet (Klonopin Wafers)	PA	<ul style="list-style-type: none"> <li>epilepsy, adjunctive therapy-gabapentin, levetiracetam, tiagabine, topiramate</li> <li>postherpetic neuralgia-gabapentin</li> </ul>
clorazepate (Tranxene-T #)		For unlabeled uses, approval will be considered based on current medical evidence.
diazepam (generics, Diastat)		<p><i>Precautions/warnings:</i></p> <ul style="list-style-type: none"> <li>About 25% to 30% of patients who experience a hypersensitivity reaction to carbamazepine will experience a hypersensitivity reaction to oxcarbazepine. Carbamazepine has been associated with aplastic anemia and agranulocytosis. Hematologic studies should be performed before therapy is initiated.</li> <li>Felbamate is not a first-line antiepileptic agent and is recommended only in patients who have shown an inadequate response to alternative treatments and whose epilepsy is so severe that the benefits outweigh the potential risks of aplastic anemia or liver failure.</li> <li>Lamotrigine has been associated with serious rashes, which required hospitalization and/or discontinuation of treatment. Most cases of life-threatening rashes occurred within the first 2 to 8 weeks of treatment.</li> <li>Phenytoin may cause gingival hyperplasia; the incidence may be reduced by good oral hygiene, including frequent brushing and flossing.</li> <li>Valproic acid and its derivatives have been associated with hepatic failure resulting in fatalities. Liver function tests should be performed prior to initiating therapy and subsequently at frequent intervals, especially during the first 6 months of therapy.</li> </ul> <p><i>See Pharmacy Program Anticonvulsant Initiative (<a href="http://www.mass.gov/druglist">www.mass.gov/druglist</a>) for more information about PA requirements for anticonvulsants.</i></p>
divalproex (Depakote)		
ethosuximide (Zarontin #)		
ethotoin (Peganone)		
felbamate (Felbatol)		
gabapentin (Neurontin #)	PA > 18 years	
gabapentin powder	PA > 18 years	
lamotrigine (Lamictal)		
levetiracetam (Keppra)	PA	
methsuximide (Celontin)		
oxcarbazepine (Trileptal)		
phenobarbital (generics)		
phenytoin (Dilantin, Phenytek)		
primidone (Mysoline #)		
tiagabine (Gabitril)	PA > 18 years	
topiramate (Topamax)	PA > 18 years	
valproate (Depacon, Depakene #)		
valproic acid (Depakene #)		
zonisamide (Zonegran)		

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**Table 21 – Beta-Adrenergic Blocking Agents**

Drug Name	PA Status	Adrenergic Receptor Blocking Activity	Clinical Notes
acebutolol (Sectral #)		$\beta_1$	<p><i>Receptor blocking selectivity:</i></p> <ul style="list-style-type: none"> <li><math>\beta_1</math> receptors are predominant in the heart and kidney; <math>\beta_2</math> receptors are predominant in the arteriolar smooth muscle, liver, lungs, and pancreas.</li> <li>Cardioselective beta-blockers possess greater affinity for <math>\beta_1</math> receptors than <math>\beta_2</math> receptors.</li> <li>At low doses, cardioselective beta-blockers may be safer than nonselective agents in patients with asthma, diabetes, COPD, and peripheral vascular disease.</li> <li>Cardioselective agents may also inhibit <math>\beta_2</math> receptors at higher doses.</li> <li>Alpha-blockade has the potential to produce more orthostatic hypotension.</li> </ul> <p><i>Intrinsic sympathomimetic activity (ISA):</i></p> <ul style="list-style-type: none"> <li>Acebutolol, carteolol, penbutolol, and pindolol possess ISA.</li> <li>Agents with ISA may not be as cardioprotective as other beta-blockers and should not be used for myocardial infarction (MI) prophylaxis.</li> </ul> <p><i>Use in heart failure:</i></p> <ul style="list-style-type: none"> <li>Metoprolol extended-release and carvedilol are approved for heart failure.</li> </ul> <p><i>Use in diabetes:</i></p> <ul style="list-style-type: none"> <li>Beta-blockers may mask some symptoms of hypoglycemia.</li> <li>Nonselective beta-blockers may potentiate insulin-induced hypoglycemia and delay recovery of serum glucose levels.</li> </ul> <p><i>Other concomitant disorders:</i></p> <ul style="list-style-type: none"> <li>Beta-blockers may offer advantages for hypertensive patients with the following conditions: angina, migraines, selected ventricular and supraventricular arrhythmias.</li> <li>All patients should receive a beta-blocker post MI, unless they have an absolute contraindication or have shown intolerance.</li> </ul>
atenolol (Tenormin #)		$\beta_1$	
atenolol/chlorthalidone (Tenoretic #)			
betaxolol (Kerlone #)		$\beta_1$	
bisoprolol (Zebeta #)		$\beta_1$	
bisoprolol/hydrochlorothiazide (Ziac #)			
carteolol (Cartrol)	PA	$\beta_1 \beta_2$	
carvedilol (Coreg)	PA	$\beta_1 \beta_2 \alpha_1$	
esmolol (Brevibloc)		$\beta_1$	
labetalol (Trandate #, Normodyne #)		$\beta_1 \beta_2 \alpha_1$	
metoprolol (Lopressor #, Toprol)		$\beta_1$	
metoprolol/hydrochlorothiazide (Lopressor HCT#)			
nadolol (Corgard #)		$\beta_1 \beta_2$	
nadolol/bendroflumethiazide (Corzide)			
penbutolol (Levitol)	PA	$\beta_1 \beta_2$	
pindolol (Visken #)		$\beta_1 \beta_2$	
propranolol (Inderal #)		$\beta_1 \beta_2$	
propranolol extended-release (InnoPran XL)	PA		
propranolol/hydrochlorothiazide (Inderide #)			
sotalol (Betapace #)		$\beta_1 \beta_2$	
timolol (Blocadren #)		$\beta_1 \beta_2$	
timolol/hydrochlorothiazide (Timolide)			

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**Table 22 – Calcium Channel Blocking Agents**

Table 22 Calcium Channel Blocking Agents		<div><b>Clinical Notes</b></div> <div><i>Indications:</i><ul style="list-style-type: none"><li>Nimodipine is only FDA approved for subarachnoid hemorrhage.</li><li>Bepiridil, diltiazem (short acting), nifedipine (immediate release), and nimodipine are not FDA approved for the treatment of essential hypertension.</li><li>Sustained-release nifedipine and amlodipine have been shown to have comparable efficacy in African-Americans with hypertension.</li></ul><i>Precautions/warnings:</i><ul style="list-style-type: none"><li>Formulations of calcium channel blockers that contain the same active ingredient may not be “A” rated to each other and therefore, should not be interchanged.</li><li>Two sustained-release verapamil products (Covera-HS and Verelan PM – not interchangeable) were designed to be given at bedtime. With a 4-5 hour delay in release, it is intended to prevent the early morning surge in blood pressure.</li></ul><i>Adverse events:</i><ul style="list-style-type: none"><li>Side effects caused by vasodilation such as dizziness, flushing, headache, and peripheral edema, occur more frequently with dihydropyridines.</li></ul></div>
Drug Name	PA Status	
<i>Benzothiazepines</i>		
bepiridil (Vascor)	PA	
diltiazem (Cardizem #, Cartia, Dilacor #, Tiazac)		
<i>Dihydropyridines</i>		
amlodipine (Norvasc)	PA	
amlodipine/atorvastatin (Caduet)	PA	
amlodipine/benazepril (Lotrel)	PA	
enalapril/felodipine (Lexxel)	PA	
felodipine (Plendil)	PA	
isradipine (Dynacirc)	PA	
nicardipine (Cardene #)		
nifedipine (Adalat #, Procardia #, Nifedical)		
nimodipine (Nimotop)		
nisoldipine (Sular)	PA	
<i>Diphenylalkylamines</i>		
trandolapril/verapamil (Tarka)	PA	
verapamil (Calan #, Verelan #, Isoptin #, Covera-HS)		

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**Table 23 – Respiratory Inhalant Products**

Drug Name	PA Status	Clinical Notes
<b>Anticholinergics</b>		<p><i>Quick-relief medications:</i></p> <ul style="list-style-type: none"><li>Inhaled short-acting selective beta<sub>2</sub>-agonists are therapy of choice for relief of acute symptoms.</li><li>Increasing use of short-acting beta<sub>2</sub>- agonists or use of more than one canister/month may indicate over reliance on this drug and inadequate asthma control.</li><li>Daily scheduled use of short-acting beta<sub>2</sub>-agonists is generally not recommended.</li><li>Salmeterol, a long acting beta<sub>2</sub>-agonist, is not recommended for treatment of acute symptoms or exacerbations.</li></ul> <p><i>Long-term-control medications:</i></p> <ul style="list-style-type: none"><li>Corticosteroids are the most potent and effective anti-inflammatory medications currently available.</li><li>The incidence of oral candidiasis with inhaled corticosteroids may be reduced by using a spacer/holding chamber, rinsing the mouth with water after inhalation and, if appropriate, administering the inhaled corticosteroid less frequently.</li><li>Long-acting inhaled beta<sub>2</sub>-agonists should be used in conjunction with anti-inflammatory medications and are especially beneficial in managing nighttime symptoms.</li><li>Formoterol and salmeterol are long-acting inhaled beta<sub>2</sub>-agonists.</li></ul> <p><i>Exercise-induced bronchospasm:</i></p> <ul style="list-style-type: none"><li>Inhaled selective beta<sub>2</sub>-agonists are the treatment of choice.</li></ul> <p><i>See Pharmacy Program Asthma Initiative (<a href="http://www.mass.gov/druglist">www.mass.gov/druglist</a>) for more information about PA requirements for respiratory inhalant products.</i></p>
ipratropium, inhalation solution, inhaler (Atrovent #)		
<b>Combination Products</b>		
albuterol/ipratropium, inhalation solution (DuoNeb), inhaler (Combivent)		
fluticasone/salmeterol, diskus (Advair)		
<b>Corticosteroids</b>		
beclomethasone, inhaler (Qvar, Vanceril)		
budesonide, inhalation suspension, inhaler (Pulmicort)		
flunisolide, inhaler (AeroBid)		
flunisolide, inhaler (AeroBid -M)	PA	
fluticasone, diskus, inhaler, rotadisk (Flovent)		
triamcinolone, inhaler (Azmacort)		
<b>Mast Cell Stabilizers</b>		
cromolyn, inhalation solution, inhaler (Intal #)		
nedocromil, inhaler (Tilade)		
<b>Sympathomimetics</b>		
albuterol, inhalation solution (AccuNeb, Proventil)		
albuterol, inhaler (generics)		
albuterol, inhaler (Proventil, Proventil HFA, Ventolin, Ventolin HFA)	PA	
formoterol (Foradil)		
isoetharine, inhalation solution		
levalbuterol, inhalation solution (Xopenex)	PA	
metaproterenol, inhalation solution (Alupent #)		
metaproterenol, inhaler (Alupent)	PA	
pirbuterol, inhaler (Maxair)	PA	
salmeterol, diskus, inhaler (Serevent)		

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**Table 24 – Atypical Antipsychotics**

Drug Name	PA Status	Clinical Notes
aripiprazole (Abilify)		<p><i>Division initiatives:</i></p> <ul style="list-style-type: none"> <li>MassHealth does not consider olanzapine a first-line therapy for treatment of psychiatric illnesses due to its side effect profile and cost.</li> <li>PA is required when a patient has an overlap of 60 days or more in prescriptions of aripiprazole, olanzapine, quetiapine, risperidone, and/or ziprasidone because there is limited scientific data to support the concomitant use of these atypical antipsychotics.</li> </ul> <p><i>Additional information:</i></p> <ul style="list-style-type: none"> <li>Aripiprazole has a 75-hour half-life. Dosages should not be increased until after at least 2 weeks of therapy. Dosages higher than 10 or 15 mg/day have not been shown to be more effective than 10 or 15 mg/day.</li> <li>Clozapine may cause agranulocytosis; therefore, white blood cell counts must be performed before initiating therapy, during therapy (initially weekly then biweekly if appropriate), and for 4 weeks after discontinuing therapy.</li> <li>Olanzapine and clozapine should be used cautiously in patients with diabetes with periodic monitoring of weight and fasting glucose.</li> <li>Risperidone doses greater than 6 mg/day are associated with more extrapyramidal symptoms.</li> </ul> <p><i>See Pharmacy Program Atypical Antipsychotics Initiative (<a href="http://www.mass.gov/druglist">www.mass.gov/druglist</a>) for more information about PA requirements for atypical antipsychotics.</i></p>
clozapine (Clozaril #)		
clozapine, orally disintegrating tablet (Fazaclo)	PA	
fluoxetine/olanzapine (Symbyax)	PA	
olanzapine (Zyprexa)		
olanzapine injection (Zyprexa IM)	PA	
olanzapine, orally disintegrating tablet (Zyprexa Zydis)	PA	
quetiapine (Seroquel)		
risperidone (Risperdal)		
risperidone injection (Risperdal Consta)		
risperidone, orally disintegrating tablet (Risperdal M)	PA	
ziprasidone (Geodon)		

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**Table 25 – Intranasal Corticosteroids**

<b>Drug Name</b>	<b>PA Status</b>	<b>Clinical Notes</b>
beclomethasone (Beconase AQ), nasal spray	PA > 1 inhaler/month	<ul style="list-style-type: none"> <li>Intranasal corticosteroids are effective in managing symptoms of itching, nasal congestion, rhinorrhea and sneezing associated with perennial and seasonal rhinitis.</li> <li>Symptoms may begin to improve in 2-3 days but full benefit may not be achieved for 2-3 weeks.</li> <li>Dosage may be reduced after a response has been achieved.</li> <li>At the recommended doses, side effects are usually minimal and include stinging, sneezing, headache and epistaxis.</li> </ul>
budesonide (Rhinocort Aqua), nasal spray	PA > 1 inhaler/2 months	
flunisolide (generics, Nasalide #, Nasarel), nasal spray	PA > 1 inhaler/month	
fluticasone (Flonase), nasal spray	PA > 1 inhaler/month	
mometasone (Nasonex), nasal spray	PA > 1 inhaler/month	
triamcinolone (Nasacort, Nasacort AQ), nasal spray	PA > 1 inhaler/month	

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Table 26 – Oral Antidiabetic Agents

Drug Name	PA Status	Clinical Notes
<b>Alpha-Glucosidase Inhibitors</b>		<i>Alpha-glucosidase inhibitors:</i> <ul style="list-style-type: none"><li>• If hypoglycemia occurs, must treat with glucose rather than sucrose.</li><li>• Not recommended for patients with significant renal dysfunction (serum creatinine &gt; 2 mg/dL).</li><li>• Contraindications include inflammatory bowel disease, colonic ulceration, and intestinal obstruction.</li></ul> <i>Biguanides:</i> <ul style="list-style-type: none"><li>• Hold metformin therapy for 48 hours after receiving iodinated contrast.</li><li>• May cause lactic acidosis; contraindicated in patients predisposed to acidosis (e.g., major surgery, congestive heart failure, hepatic failure).</li><li>• Contraindicated in females and males with renal disease or dysfunction (e.g., serum creatinine greater than or equal to 1.4 mg/dL and 1.5 mg/dL, respectively).</li><li>• In small studies, some obese women with polycystic ovary syndrome experienced a return of normal menses and ovulation when treated with metformin.</li></ul> <i>Meglitinides:</i> <ul style="list-style-type: none"><li>• Take <u>before</u> meals; hold dose if meal is missed.</li><li>• Use with caution in patients with hepatic impairment.</li></ul> <i>Sulfonylureas:</i> <ul style="list-style-type: none"><li>• Use with caution in elderly patients, and patients with renal or hepatic impairment.</li></ul> <i>Thiazolidinediones:</i> <ul style="list-style-type: none"><li>• Use with caution in patients with edema.</li><li>• Not recommended for patients with NYHA class III-IV cardiac status.</li><li>• Not recommended for patients with liver function tests greater than 2.5 times normal.</li><li>• May cause resumption of ovulation in premenopausal anovulatory women with insulin resistance.</li></ul> <i>Pregnancy/lactation:</i> <ul style="list-style-type: none"><li>• Insulin is the agent of choice during pregnancy and lactation.</li></ul>
acarbose (Precose)	PA	
miglitol (Glyset)	PA	
<b>Biguanides</b>		
metformin (Glucophage #)		
metformin extended-release (Fortamet)	PA	
metformin extended-release (Glucophage XR #)		
metformin solution (Riomet)		
<b>Meglitinides</b>		
nateglinide (Starlix)	PA	
repaglinide (Prandin)	PA	
<b>Sulfonylureas - First Generation</b>		
acetohexamide		
chlorpropamide (Diabenese #)		
tolazamide (Tolinase #)		
tolbutamide		
<b>Sulfonylureas - Second Generation</b>		
glimepiride (Amaryl)	PA	
glipizide (Glucotrol #)		
glipizide extended-release (Glucotrol XL #)		
glyburide (Diabeta)	PA	
glyburide (Micronase #)		
glyburide, micronized (Glynase #)		
<b>Thiazolidinediones</b>		
pioglitazone (Actos)		
rosiglitazone (Avandia)		
<b>Combination Products</b>		
glipizide/metformin (Metaglip)	PA	
glyburide/metformin (Glucovance)	PA	
metformin/rosiglitazone (Avandamet)	PA	

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**Therapeutic Class Tables (cont.)**

**Table 27 – 5HT<sub>3</sub> Receptor Antagonists**

Drug Name	PA Status	Clinical Notes
Anzemet (dolasetron) tablet	PA > 15 units/month	<ul style="list-style-type: none"> <li>Granisetron and ondansetron are FDA approved for the prevention/treatment of postoperative, chemotherapy-induced, and radiation-induced nausea and vomiting.</li> <li>Anzemet is not FDA approved for the prevention of radiation-induced nausea and vomiting.</li> <li>Anzemet is associated with more drug interactions than Kytril or Zofran.</li> <li>Anzemet has a cardiac warning and can prolong the QTc interval.</li> <li>Dolasetron is FDA approved for prevention/treatment of postoperative and chemotherapy-induced nausea and vomiting.</li> <li>Dolasetron should be administered with caution in patients who have or may develop prolongation of cardiac conduction intervals, particularly QTc. These include patients with hypokalemia or hypomagnesemia, patients taking diuretics with potential for inducing electrolyte abnormalities, patients with congenital QT syndrome, patients taking antiarrhythmic drugs or other drugs that lead to QT prolongation, and cumulative high-dose anthracycline therapy.</li> </ul>
Kytril (granisetron) tablet	PA > 15 units/month	
Kytril (granisetron) solution (2 mg/10 ml)	PA > 30 mL/month	
Zofran (ondansetron) 4 mg and 8 mg tablets	PA > 15 units/month	
Zofran (ondansetron) 24 mg tablets	PA > 5 units/month	
Zofran (ondansetron) orally disintegrating tablets	PA > 15 units/month	
Zofran (ondansetron) solution (4 mg/5 ml)	PA > 50 mL/month	



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Anticonvulsant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Keppra. PA is required for Gabitril, Neurontin, and Topamax for members older than 18 years. Information about anticonvulsants can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information: Section I

<b>Anticonvulsant request</b> (Check one or all that apply) <input type="checkbox"/> Gabitril (tiagabine) <input type="checkbox"/> Keppra (levetiracetam) <input type="checkbox"/> Neurontin (gabapentin) <input type="checkbox"/> Topamax (topiramate)	Dose, frequency, and duration of requested drug	Drug NDC (if known) or service code
	Indication for anticonvulsant requested (Check one or all that apply.) <input type="checkbox"/> Seizure disorder Type: _____ <input type="checkbox"/> Postherpetic neuralgia (gabapentin only) <input type="checkbox"/> Other (describe): _____ _____	
	Please list all other medications currently prescribed for the member for this indication. _____ _____	
Is member currently hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has member ever been hospitalized for this condition? <input type="checkbox"/> Yes. Dates of most recent hospitalization: _____ <input type="checkbox"/> No		
Is member under the care of a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is member under the care of a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of neurologist and/or psychiatrist: _____ Telephone no.: _____		
Date of last visit with neurologist and/or psychiatrist: _____		

Medication information: Section II

Please complete this section if indication is NOT for a seizure disorder. (This section does not need to be completed if indication is for a seizure disorder.)

Has member tried other medications for this condition?

- ☐ Yes. Complete box A.
- ☐ No. Explain why not. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has member previously tried requested anticonvulsant?

- ☐ Yes. Complete box B.
- ☐ No. Explain why not. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

A. Drug name

Dates of use

Dose and frequency

Briefly describe details of adverse reaction, inadequate response, intolerance, or other.

\_\_\_\_\_

\_\_\_\_\_

**Note:** You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

B. Drug name

Dates and length of use

Maximum daily dose

Briefly describe how member responded to the requested anticonvulsant.

\_\_\_\_\_

\_\_\_\_\_

**Note:** You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Pharmacy information

Name

Pharmacy provider no.

Telephone no.  
(     )

Fax no.  
(     )

Address

City

State

Zip

Prescriber information

Last name

First name

MI

MassHealth provider no.

DEA no.

Address

City

State

Zip

E-mail address

Telephone no.  
(     )

Fax no.  
(     )

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber’s signature (Stamp not accepted.)

Date



Commonwealth of Massachusetts

**MassHealth Drug Utilization Review Program**

P.O. Box 2586

Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Antidepressant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Celexa, Cymbalta, Effexor, Effexor XR, Lexapro, mirtazapine orally disintegrating tablets, paroxetine for members < 18 yrs of age, Paxil CR, Pexeva, Prozac Weekly, Remeron Soltab, Sarafem, Symbyax, Zoloft, Wellbutrin XL, and brand-name multiple-source antidepressants that have an FDA "A"-rated generic equivalent. Additional information about antidepressants can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

<b>Antidepressant request</b> <input type="checkbox"/> Celexa <input type="checkbox"/> Cymbalta <input type="checkbox"/> Effexor <input type="checkbox"/> Effexor XR <input type="checkbox"/> Lexapro <input type="checkbox"/> mirtazapine orally disintegrating tablet <input type="checkbox"/> paroxetine for member <18 yrs of age <input type="checkbox"/> Paxil CR <input type="checkbox"/> Pexeva <input type="checkbox"/> Prozac Weekly <input type="checkbox"/> Remeron Soltab <input type="checkbox"/> Sarafem <input type="checkbox"/> Symbyax <input type="checkbox"/> Zoloft <input type="checkbox"/> Wellbutrin XL <input type="checkbox"/> Brand Name _____ <input type="checkbox"/> Other _____	Dose, frequency, and duration of requested drug  Indication for antidepressant requested (Check all that apply.) <input type="checkbox"/> Depression <input type="checkbox"/> Obsessive-compulsive disorder <input type="checkbox"/> Other (describe): _____ _____ _____  <input type="checkbox"/> Panic disorder <input type="checkbox"/> Premenstrual dysphoric disorder  Please list all other psychotropic medications currently prescribed for the member. _____ _____ _____	Drug NDC (if known)
Has member been hospitalized for this condition? <input type="checkbox"/> Yes. Dates of most recent hospitalization _____ <input type="checkbox"/> No		
Is member under the care of a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of psychiatrist _____ Telephone no. _____		
Date of last visit or consult with psychiatrist _____		

## Medication information continued

Has member tried fluoxetine, fluvoxamine, or paroxetine?

☐ Yes. Complete box A.

☐ No. Explain why not.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has member previously tried requested antidepressant?

☐ Yes. Complete box B.

☐ No.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### A. Drug name

Dates of use

Dose and frequency

Did member experience any of the following?

☐ Adverse reaction    ☐ Inadequate response    ☐ Intolerance    ☐ Other

☐ Concern about drug interaction with \_\_\_\_\_

Briefly describe details of adverse reaction, inadequate response, intolerance, or other.

\_\_\_\_\_  
\_\_\_\_\_

**Note:** You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

### B. Drug name

Dates of use

Dose and Frequency

Briefly describe how member responded to the requested antidepressant.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note:** You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State    Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State    Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date





Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Antipsychotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Risperdal M and Zyraxa Zydis. Brand-name Clozaril requires PA because it has an FDA "A"-rated generic. (Please use the Brand Name Drug Prior Authorization Request form for PA requests for brand-name Clozaril.)

PA is required for duplicative antipsychotic pharmacotherapy, or an overlap of 60 days or more in prescriptions (for any dosage form), of two or more of the following atypical antipsychotics: Abilify, Geodon, Risperdal, Seroquel, and Zyraxa. Additional information about antipsychotics can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth)

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence		<input type="checkbox"/> home	<input type="checkbox"/> nursing facility		

### Medication information

Indication for antipsychotic requested (Check one or all that apply.) <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Other: _____	
Has member been hospitalized for this condition? <input type="checkbox"/> Yes. Dates of most recent hospitalization: _____ <input type="checkbox"/> No	
Is member under the care of a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of psychiatrist: _____ Telephone no.: _____	
Date of last visit with psychiatrist: _____	
<b>Section I</b>  <b>Please complete Section I for a PA request for any of the following:</b>  <input type="checkbox"/> Risperdal M <input type="checkbox"/> Zyraxa Zydis <input type="checkbox"/> Other: _____	Dose, frequency, and duration of requested antipsychotic  Drug NDC (if known) or service code  Please explain rationale for requested dosage form(s) or other. _____ _____  Has member tried other medications to treat this condition? <input type="checkbox"/> Yes. Please provide details of previous treatment(s), including drug name(s), dates of use and response to treatment(s). _____ _____  <input type="checkbox"/> No. Explain why not. _____ _____  Please list all other psychotropic medications currently prescribed for this member. _____ _____

## Medication information (cont.)

<b>Section II</b> <b>Please complete Section II for a PA request due to duplicative antipsychotic pharmacotherapy.</b> <input type="checkbox"/> Abilify (aripiprazole) <input type="checkbox"/> Geodon (ziprasidone) <input type="checkbox"/> Risperdal (risperidone) <input type="checkbox"/> Seroquel (quetiapine) <input type="checkbox"/> Zyprexa (olanzapine)	Dose, frequency, and duration of first requested antipsychotic	Drug NDC (if known) or service code
	Dose, frequency, and duration of second requested antipsychotic	Drug NDC (if known) or service code
	Please describe trial with each individual agent as monotherapy and start dates.  _____ _____ _____ _____  Please list all other psychotropic medications currently prescribed for the member.  _____ _____ _____ _____	

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
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Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Erythropoietin Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all erythropoietin products. Information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence	<input type="checkbox"/> home	<input type="checkbox"/> nursing facility	Height	Weight	

### Medication information (When appropriate, please consider multidose vial use.)

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code
<b>Indication for erythropoietin</b> (Check one or all that apply.):		
<input type="checkbox"/> Chronic renal failure Is the member on hemodialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please Note: If member is on hemodialysis, please contact dialysis clinic for proper billing procedure.) Please provide most recent serum creatinine and/or creatinine clearance.  _____ _____ _____		
<input type="checkbox"/> HIV Please provide medication regimen.  _____ _____ _____		
<input type="checkbox"/> Anemic surgical patient Type of procedure: _____ Date of procedure: _____  Please provide medical necessity for the use of erythropoietin:  _____ _____ _____		
<input type="checkbox"/> Renal transplant		
<input type="checkbox"/> Cancer chemotherapy Please provide type of cancer and dates chemotherapy will be given.  _____ _____ _____		
<input type="checkbox"/> Other Please provide medical necessity for the use of erythropoietin  _____ _____ _____ _____		
<input type="checkbox"/> Hepatitis C Please provide antiviral medication regimen and any dose adjustments attempted.  _____ _____ _____		

Laboratory information

Current Hematocrit/Hemoglobin: \_\_\_\_\_ date: \_\_\_\_\_

Erythropoietin level (if available): \_\_\_\_\_

Have other causes of anemia been ruled out (hemolysis, iron, vitamin B12, and folate deficiency)? Yes ☐ No ☐

If no, please provide further justificatiion for erythropoietin.  
\_\_\_\_\_

Continuation of therapy

Please complete sections above about indication for erythropoietin and labratory information.

Please provide documentation of member’s response to therapy (e.g., quality of life, activities of daily living).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has member been transfused in past six months? ☐ Yes ☐ No

If yes, please provide explanation. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Target hematocrit: \_\_\_\_\_  
\_\_\_\_\_

If target hematocrit has been met, please provide plan for decreasing dose. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber’s signature (Stamp not accepted.) \_\_\_\_\_ Date \_\_\_\_\_



Commonwealth of Massachusetts  
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**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Forteo Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Forteo.

Additional information about Forteo can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

#### Section I

##### Forteo 20 mcg SQ once a day

Forteo \_\_\_\_\_ (Please specify dosing regimen and rationale for this regimen.)

Indication for Forteo (Check one or all that apply.)

☐ Post menopausal osteoporosis (PMO) ☐ Primary/Hypogonadal osteoporosis ☐ Other: \_\_\_\_\_

Has member had a radiographically confirmed fracture?

☐ Yes. Please provide site of fracture and date of occurrence (if known): \_\_\_\_\_

☐ No.

Date/results of baseline BMD measurements: Please provide baseline T-scores of total hip and lumbar vertebrae (L1-L4).

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Date/results of any subsequent BMD measurements: Please provide T-scores of total hip and lumbar vertebrae (L1-L4).

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Is member under the care of a rheumatologist or endocrinologist? ☐ Yes ☐ No

Name of rheumatologist or endocrinologist: \_\_\_\_\_

Date of last visit with rheumatologist or endocrinologist: \_\_\_\_\_

Please list all supplements and medications currently prescribed for this member.

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Please list all non-modifiable risk factors for fracture in this member.

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## Medication information (cont.)

### Section II

#### Has member tried alendronate (Fosamax) to treat this condition?

☐ Yes. Complete box A. ☐ No. Explain why not. \_\_\_\_\_

#### A. Dates of use

#### Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: \_\_\_\_\_

#### Has member tried risedronate (Actonel) to treat this condition?

☐ Yes. Complete box B. ☐ No. Explain why not. \_\_\_\_\_

#### B. Dates of use

#### Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: \_\_\_\_\_

#### Has member tried raloxifene (Evista) to treat this condition?

☐ Yes. Complete box C. ☐ No. Explain why not. \_\_\_\_\_

#### C. Dates of use

#### Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: \_\_\_\_\_

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date



Commonwealth of Massachusetts  
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Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

# Fuzeon Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for Fuzeon. Additional information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

## Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	<input type="checkbox"/> home	<input type="checkbox"/> nursing facility	Height	Weight	

## Medical and medication information (Please provide copies of all pertinent medical records.)

**Laboratory Results**

Date	CD4 (cells/ml)	Plasma RNA (copies/ml)

If the CD4 count is > 500 cells/ml or plasma RNA is < 1000 copies/ml, please provide further justification for Fuzeon use.

**Resistance testing**

Please provide documentation of 2-class resistance, including copies of genotype/phenotype. If not available, please provide further justification for Fuzeon use (treatment history, etc.).

**Intolerance to medications**

Please list adverse reactions to antiretroviral medications.

**Treatment plan**

Please provide proposed treatment plan.

## Medical and medication information (cont.)

Fuzeon dose ☐ 90 mg SC BID

Other (specify) \_\_\_\_\_

Please explain rationale for doses other than Fuzeon 90 mg SC BID.

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### Continuation of therapy

If member is currently receiving Fuzeon therapy, please provide date started: \_\_\_\_\_

Please list baseline (CD4 (cells/ml) and plasma RNA (copies/ml) prior to start of Fuzeon.)

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---

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I understand that if this patient does not show an adequate response to this medication within six months, reapproval will not be granted.  
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date





Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## G-CSF/GM-CSF Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all G-CSF/GM-CSF products. Information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence	<input type="checkbox"/> home	<input type="checkbox"/> nursing facility	Height	Weight	

### Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code
<b>Indication for G-CSF/GM-CSF</b> (Check one or all that apply):		
<input type="checkbox"/> Autologous bone marrow transplant		
<input type="checkbox"/> Chronic neutropenia Etiology _____		
<input type="checkbox"/> Peripheral blood progenitor cell collection and therapy		
<input type="checkbox"/> Other (please explain): _____ _____ _____		
<input type="checkbox"/> Drug induced neutropenia (Check one or all that apply.)		
<input type="checkbox"/> Cancer chemotherapy: Indicate type of cancer and chemotherapy regimen including dates, frequency, and duration. _____ _____ _____		
<input type="checkbox"/> Hepatitis C Indicate dates and current dosages of medication regimen. _____ _____ _____		
Has dose adjustment been attempted? (Check one or all that apply.):		
<input type="checkbox"/> Yes. Please provide details. _____		
<input type="checkbox"/> No. Explain why not. _____ _____		
<input type="checkbox"/> HIV Is member currently receiving antiretroviral therapy? (Check one or all that apply.):		
<input type="checkbox"/> Yes. Please provide details. _____		
<input type="checkbox"/> No. Explain why not. _____ _____		

## Laboratory monitoring

Please provide date and results of the most recent CBC with differential or absolute neutrophil count (ANC).

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber’s signature (Stamp not accepted.)

Date



Commonwealth of Massachusetts  
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Worcester, MA 01613-2586

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## Growth Hormone Adult Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all growth hormone products. Information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

Drug name requested	Dose, frequency, and duration		Drug NDC (if known) or service code
Indication for GH: For HIV wasting, fill out Section A. For growth hormone deficiency (GHD) syndrome in adults, fill out Section B.			
<b>Section A</b>			
<b>HIV wasting - Initial prior authorization</b>			
Current height	Current weight	Date	
Premorbid weight	Date	Diagnosis	
CD4 count	Date	Has member intentionally lost weight?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe attempted nutritional supplementation _____ _____ _____			
Has member attempted therapy with dronabinol (Marinol) or megestrol acetate (Megace)? If so, provide dates and duration. If not, please explain why. _____ _____ _____			
Describe current antiretroviral therapy. _____ _____			
Any known tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this a female patient who is pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>HIV wasting - Reauthorization</b>			
Current height	Current weight	Date	
Has member maintained or gained weight with GH treatment? _____			

## Medication information (cont.)

### Section B

#### Growth hormone deficiency (GHD) syndrome in adults

Current height	Current weight	Date
Is the growth hormone deficiency adult onset? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, provide etiology of GH deficiency. _____ _____		
Please provide dates and results of GH stimulation tests performed. If stimulation test was not performed, please explain why not. _____ _____		
IGF-I level	Date	
Provide detailed signs and symptoms of growth hormone deficiency syndrome and provide documentation of diagnostic procedures, lab tests, radiological tests, and clinical findings. _____ _____		
Any known tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a female patient who is pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Provide date of last appointment with endocrinologist		

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address	City	State	Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address	City	State	Zip	
E-mail address	Telephone no. (     )	Fax no. (     )		

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
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Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Growth Hormone Pediatric Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all growth hormone products. Information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code	
<b>GH pediatric indications</b> Indication for growth hormone requested (Check one or all that apply.) <input type="checkbox"/> Growth hormone deficiency <input type="checkbox"/> Prader Willi syndrome (Provide documentation of genetic testing) <input type="checkbox"/> Growth reduction due to chronic renal failure <input type="checkbox"/> Small for gestational age with failed catch-up by age 2 <input type="checkbox"/> Noonan syndrome <input type="checkbox"/> Turner syndrome (Provide documentation of genetic testing.) <input type="checkbox"/> Other: _____ _____			
Fill in applicable information below. You may be asked to provide supporting documents (e.g., copies of medical records, office notes, growth charts, diagnostic studies, laboratory tests and/or completed MedWatch form).			
Current height	Current weight	Date	
Growth rate in past year	cm	Date of GH stimulation tests	
Provide type of GH stimulation tests performed and results _____			
IGF-I level	Date	Bone age exam results	Date
Any known tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this a female patient who is pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Provide date of last appointment with endocrinologist.			

Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber’s signature (Stamp not accepted.)

Date



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## Hypnotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Doral (single-source brand-name benzodiazepine) and any brand-name multiple-source benzodiazepine that has an FDA "A"-rated generic equivalent as identified by the **Approved Drug Products with Therapeutic Equivalence Evaluations** (also called the "Orange Book").

PA is also required for quantity requests greater than 10 units per month for hypnotics. Additional information about hypnotic use can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence		<input type="checkbox"/> home	<input type="checkbox"/> nursing facility		

### Medication information

Hypnotic request	Quantity	Dose, frequency, and duration of requested drug	Drug NDC (if known)						
<input type="checkbox"/> Ambien (zolpidem) <input type="checkbox"/> Dalmane # (flurazepam) <input type="checkbox"/> Doral (quazepam) <input type="checkbox"/> Halcion # (triazolam) <input type="checkbox"/> ProSom # (estazolam) <input type="checkbox"/> Restoril # (temazepam) <input type="checkbox"/> Sonata (zaleplon) <input type="checkbox"/> Other _____	_____ _____ _____ _____ _____ _____ _____ _____	<p>A. If request is for Doral or any brand-name multiple-source benzodiazepine (as denoted by the # symbol), please complete Sections I and II.</p> <p>B. If request is for quantities greater than 10 units per month, please complete Section II.</p>							
<b>Section I</b> <p>Please complete this section for requests for Doral or brand-name multiple-source benzodiazepine.</p> <p>Attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).</p>		<p>Has member tried a generic benzodiazepine?</p> <p><input type="checkbox"/> Yes. Please complete the following information. <input type="checkbox"/> No. Explain why not.</p> <table><tr><td>Drug name</td><td>_____</td></tr><tr><td>Dates of use</td><td>_____</td></tr><tr><td>Dose and frequency</td><td>_____</td></tr></table> <p>Did member experience any of the following?</p> <p><input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other</p> <p>Briefly describe details of adverse reaction, inadequate response, or other.</p> <p>_____ _____ _____</p> <p><input type="checkbox"/> No.</p>		Drug name	_____	Dates of use	_____	Dose and frequency	_____
Drug name	_____								
Dates of use	_____								
Dose and frequency	_____								

## Medication information

### Section II

Please attach supporting documentation (e.g., copies of medical records, office notes, sleep evaluation) for your response to **each** question.

If the request is for quantities greater than 10 units per month of a hypnotic, please attach a detailed description of your treatment plan of the condition for which you have requested the hypnotic. Include all nonpharmacologic and pharmacologic interventions, therapeutic endpoints, and a list of the member's current medications.

**A.** Indication for hypnotic

- ☐ Acute insomnia  
☐ Other \_\_\_\_\_

☐ Transient insomnia

**B.** Is insomnia secondary to a vital concurrent medication or diagnosis?

- ☐ Yes. Briefly describe and attach documentation.

☐ No.

**C.** Has member had a sleep evaluation?

- ☐ Yes. Briefly describe and attach documentation.

☐ No. Explain why not.

**D.** Has member been counseled on good sleep hygiene practices?

- ☐ Yes. Briefly describe and attach documentation.

☐ No. Explain why not.

**E.** Is request for quantities greater than 10 units per month of a hypnotic?

- ☐ Yes. Briefly describe and attach documentation, including detailed treatment plan.

☐ No.

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date





Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Immune Globulin Intravenous (IGIV) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

IGIV requires prior authorization. Additional information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility			Height	Weight	

### Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code
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Provide rate of administration. **Note:** Rate of administration may require adjustment for members with or at risk for renal dysfunction.

**Indication for IGIV** (Check one or all that apply.):

<input type="checkbox"/> Immunodeficiency syndrome	<input type="checkbox"/> Pediatric HIV infection Provide date and result of most recent CD4 count _____
<input type="checkbox"/> Idiopathic thrombocytopenic purpura (ITP)	_____
<input type="checkbox"/> B-cell chronic lymphocytic leukemia (CLL)	<input type="checkbox"/> Other (describe): _____ _____ _____ _____ _____
<input type="checkbox"/> Kawasaki disease Provide date of onset: _____	
<input type="checkbox"/> Bone marrow transplantation Provide type and date of transplant. _____ _____	

Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber’s signature (Stamp not accepted.)

Date



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Narcotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Information about the MassHealth Drug List can be found at **[www.mass.gov/masshealth](http://www.mass.gov/masshealth)**. Please refer to the Therapeutic Class Tables and Pain Initiative for specific information regarding prior authorization requirements for narcotics.

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

<p>PA is required for:</p> <ul style="list-style-type: none"><li>-oxycodone controlled-release (OxyContin):</li><li>-fentanyl transdermal (Duragesic)</li></ul> <p>*Members will be exempt from PA if a pharmacy received a paid claim for these drugs for the member within the past 90 days and are filling no more than 30 patches/month or 200mcg/hr of fentanyl transdermal (Duragesic) or 90 tablets/month of oxycodone controlled-release (OxyContin).</p> <p>PA is required for the following doses:</p> <ul style="list-style-type: none"><li>-oxycodone controlled-release (OxyContin) &gt; 240 mg/day</li><li>-fentanyl transdermal (Duragesic) &gt; 200mcg/hr</li><li>-levorphanol &gt; 32mg/day</li><li>-methadone &gt; 120 mg/day</li><li>-morphine controlled-release (MS Contin, Oramorph SR, generics) &gt; 360 mg/day</li><li>-morphine sustained-release (Kadian) &gt; 360 mg/day</li><li>-codeine &gt; 360mg/day</li><li>-hydromorphone &gt; 60 mg/day</li><li>-meperidine &gt; 750mg/day</li><li>-morphine immediate-release &gt; 360mg/day</li><li>-oxycodone immediate-release &gt; 240 mg/day</li></ul> <p>PA is required for the following quantities:</p> <ul style="list-style-type: none"><li>-oxycodone controlled-release (OxyContin) &gt; 90 tabs/mo.</li><li>-fentanyl transdermal (Duragesic) &gt; 30 patches/mo.</li></ul> <p>Other narcotics may also require PA.</p>	<p>Drug Name (Requested)</p> <p>Dose and frequency of requested drug</p> <p>Expected duration of therapy <input type="checkbox"/> &lt; 6 months <input type="checkbox"/> ≥ 6 months</p> <p><b>Indication</b></p> <p><input type="checkbox"/> Cancer pain (specify type and stage): _____</p> <p><input type="checkbox"/> AIDS: _____</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>-If request is for oxycodone controlled-release or fentanyl transdermal, please complete section I (and section II if applicable).</p> <p>-If request is for narcotic that exceeds dose/quantity limit, please complete section II (and section I if applicable).</p>
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### Section I

Please complete for oxycodone controlled-release or fentanyl transdermal requests.

Has member tried sustained-release or controlled-release morphine?

Yes. Please complete box at the top of page 2.

No. Please explain why not.

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(cont.)

Dates of use	Dose and frequency
Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other	
Details of adverse reaction, inadequate response, or other: _____ _____ _____	

## Medication information

<b>Section II</b> Please complete for dose/quantity limit requests.	Is the member under the care of a pain specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of specialist: _____ Phone no.: ( ) _____
	Date of last visit or consult with pain specialist: _____ Please attach copy of pain consult note if available.
	What is the complete pain-management regimen, including other pain medications, adjunctive therapy, and/or controlled substances? Please include the names and doses of these medications. _____ _____ _____
	Has the member had a psychological evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member: have a history of substance abuse or dependence? <input type="checkbox"/> Yes <input type="checkbox"/> No have a history of alcohol abuse or dependence? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the member have a treatment agreement (e.g., lock-in pharmacy and prescriber, early refill policy, consequences of nonadherence to treatment)? <input type="checkbox"/> Yes (Attach copies.) <input type="checkbox"/> No (Explain why not.) _____ _____	

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )
Address		City	State Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State Zip
E-mail address			Telephone no. ( )	Fax no. ( )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) \_\_\_\_\_ Date \_\_\_\_\_



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Nonsteroidal Anti-Inflammatory Drugs (NSAID) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Bextra, Celebrex, Mobic, and Arthrotec. In addition, PA is required for Ponstel (single-source brand-name NSAID) and any brand-name multiple-source NSAID that has an FDA "A"-rated generic equivalent as identified by the **Approved Drug Products with Therapeutic Equivalence Evaluations** (also called the "Orange Book"). Additional information about nonsteroidal use can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID #	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

 Please complete section 1 below **or** section 2 on back, depending on the drug requested.

<b>1. Cox-2 Inhibitor/ Arthrotec request</b> <input type="checkbox"/> Arthrotec (misoprostol/diclofenac) <input type="checkbox"/> Celebrex (celecoxib) <input type="checkbox"/> Bextra (valdecoxib) <input type="checkbox"/> Mobic (meloxicam)	Dose, frequency, and duration of requested drug  Is member under 60 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug NDC (if known)
Indications (Check one.) <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Primary dysmenorrhea <input type="checkbox"/> Familial adenomatous polyposis (celecoxib only: FDA-approved) <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Acute pain <input type="checkbox"/> Other, specify _____		
<b>Is member at risk for a clinically significant gastrointestinal event, as defined by one of the following?</b>		
<input type="checkbox"/> Yes (Check one.)	<input type="radio"/> Previous history: <input type="checkbox"/> Major GI bleed <input type="checkbox"/> Perforation <input type="checkbox"/> Obstruction	Dates
	<input type="radio"/> Previous history of a peptic ulcer documented by endoscopy or radiograph	Dates
<input type="checkbox"/> Concomitant therapy with any of the following (Check one.)		
	<input type="radio"/> Aspirin <input type="radio"/> Oral corticosteroid: dose, frequency, and duration _____	<input type="radio"/> Warfarin: dose, frequency, and duration _____
<input type="checkbox"/> No. Has member tried two generic NSAID products?		
	<input type="radio"/> Yes. Complete boxes 3A and 3B on back (Generic NSAID product courses).	<input type="radio"/> No. Explain why not. _____ _____ _____ _____

## Medication information continued

<b>2. Brand-name multiple-source NSAID or Ponstel request</b>	Dose, frequency, and duration of requested drug	Drug NDC (if known)
Diagnosis pertinent to requested medication		
Has member tried two generic products?		
<input type="checkbox"/> Yes. Complete boxes 3A and 3B below (Generic NSAID product courses).		
<input type="checkbox"/> No. Explain why not.		

## 3. Generic NSAID product courses

<b>A. Drug name</b>	<b>B. Drug name</b>
Dates of generic use	Dates of generic use
Dose and frequency	Dose and frequency
Did member experience any of the following?	Did member experience any of the following?
<input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other	<input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other
Details of adverse reaction, inadequate response, or other	Details of adverse reaction, inadequate response, or other

## Pharmacy information

Name	Pharmacy provider no.	Telephone (   )	Fax (   )
Address		City	State   Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA #
Address			City	State   Zip
E-mail address			Telephone (   )	Fax (   )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.)

Date

## DUR program use only

Reviewer's decision	<input type="checkbox"/> Approved	<input type="checkbox"/> Pended	<input type="checkbox"/> Denied
Comments/reasons for pended or denied decision			



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Proton Pump Inhibitor Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Aciphex, Nexium, and omeprazole and brand-name multiple-source proton pump inhibitors that have an FDA "A"-rated generic equivalent. PA is required for Prevacid for members older than 16 years old (except for use of Prevacid suspension for members in long-term-care facilities). Protonix does not require PA. Additional information about PPI use can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID #	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Indication for proton pump inhibitor

<input type="checkbox"/> <b>GERD</b> <input type="checkbox"/> Moderate-severe erosive esophagitis <input type="checkbox"/> Uncomplicated non-erosive esophagitis Has an H <sub>2</sub> antagonist previously been tried? <input type="checkbox"/> Yes. State drug name, dose, frequency, and duration. _____ _____ <input type="checkbox"/> No. Explain why not. _____ _____ <input type="checkbox"/> Barrett's esophagus or esophageal strictures <input type="checkbox"/> GERD in child with one of the following conditions: <input type="checkbox"/> Severe chronic respiratory disease (specify): _____ _____ <input type="checkbox"/> Neurologic disability (specify): _____ _____ <input type="checkbox"/> Other (specify): _____ _____ <input type="checkbox"/> <b>Condition associated with extraesophageal symptoms secondary to gastric reflux</b> <input type="checkbox"/> Non-cardiac chest pain <input type="checkbox"/> Asthma <input type="checkbox"/> Idiopathic hoarseness <input type="checkbox"/> Chronic laryngitis <input type="checkbox"/> Other (explain): _____ _____ <input type="checkbox"/> <b>other</b> (explain): _____	<input type="checkbox"/> <b>Duodenal ulcer</b> <input type="checkbox"/> <b>Gastric ulcer</b> <input type="checkbox"/> Helicobacter pylori: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Drug-induced: <input type="checkbox"/> Treatment: List causative agent(s): _____ _____ <input type="checkbox"/> Prevention: List risk factor(s): _____ _____ <input type="checkbox"/> Other cause (specify): _____ _____ <input type="checkbox"/> <b>Non-ulcer or functional dyspepsia</b> Has an H <sub>2</sub> antagonist previously been tried? <input type="checkbox"/> Yes. State drug name, dose, frequency, and duration. _____ _____ <input type="checkbox"/> No. Explain why not. _____ _____ <input type="checkbox"/> <b>Pathological hypersecretory syndromes</b> <input type="checkbox"/> Zollinger-Ellison syndrome <input type="checkbox"/> MEN Type I <input type="checkbox"/> Other: _____
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## Diagnostic studies performed (include dates of studies)

Describe any diagnostic studies performed, including dates of studies.

## Medication information

**Important Note:** For maximum efficacy, a proton pump inhibitor (PPI) must be taken in a fasting state, just before or with breakfast. If a second dose is necessary, the second dose should be given just before the evening meal. In general, it is not necessary to prescribe other antisecretory agents (H<sub>2</sub> antagonists, prostaglandins) for patients on PPIs. If an antisecretory agent is prescribed with a PPI, the PPI should not be taken within six hours of the antisecretory agent.

PPI requested	Dose, frequency, and duration of PPI	Drug or service code
<b>Has member tried Protonix? (Note: Protonix does not require prior authorization.)</b>		
<input type="checkbox"/> Yes. Provide the following information about the use of Protonix.		<input type="checkbox"/> No. Explain why not.
Dates of use	Dose and frequency	
If member received Protonix, why was it discontinued? (Check one or all that apply.)		
<input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Other		
Details of adverse reaction, inadequate response, intolerance, or other: _____		
_____		
_____		
_____		

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State    Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State    Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.)

Date





Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Statin Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for quantities greater than 30 units per month for all statins. In addition to the quantity limits, PA is required for Advicor, Altocor, Mevacor, Pravachol, Vytorin, and Zocor. **PA will not be required for quantities less than or equal to 30 units per month for Crestor, Lescol, Lescol XL, Lipitor, or generic lovastatin.** Additional information about statins can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

Please complete if the request is for quantities greater than 30 units/month.		Dose, frequency, and duration of requested drug	Drug or service code
<b>Statin request</b>	<b>Quantity per month</b>	Indication for statin requested (Check one or all that apply.)	
<input type="checkbox"/> Advicor	_____	<input type="checkbox"/> Hypertriglyceridemia <input type="checkbox"/> Primary hypercholesterolemia	
<input type="checkbox"/> Altocor	_____	<input type="checkbox"/> Mixed dyslipidemia <input type="checkbox"/> Secondary prevention of cardiovascular event	
<input type="checkbox"/> Crestor	_____	<input type="checkbox"/> Other. Specify pertinent medical history, diagnostic studies, and/or laboratory results.	
<input type="checkbox"/> Lescol	_____	_____	
<input type="checkbox"/> Lescol XL	_____	_____	
<input type="checkbox"/> Lipitor	_____	_____	
<input type="checkbox"/> lovastatin	_____	_____	
<input type="checkbox"/> Mevacor (brand name)	_____	_____	
<input type="checkbox"/> Pravachol	_____	_____	
<input type="checkbox"/> Vytorin	_____	_____	
<input type="checkbox"/> Zocor	_____	_____	
<input type="checkbox"/> Other _____	_____	_____	

#### Section I Please complete Section I if your request is for more than 30 units per month.

Please provide a rationale for requested dose, quantity and frequency, including a detailed treatment plan. (Specify pertinent medical history, diagnostic studies and/or lab results.)

\_\_\_\_\_

\_\_\_\_\_

Is member a candidate for dose consolidation? (e.g., member is on Lipitor 10 mg BID, and dose can be consolidated to Lipitor 20 mg QD, **which does not require PA**). ☐ Yes ☐ No

Please provide rationale for a regimen of greater than one unit per day. \_\_\_\_\_

\_\_\_\_\_

## Medication information (cont.)

**Section II** Please complete Section II if your request is for Advicor, Altocor, Mevacor (brand name), Pravachol, Zocor or Other.

Has member tried two of the following statins: Crestor, Lescol/Lescol XL, Lipitor, or generic lovastatin?

☐ Yes. Complete boxes A and B.

☐ No. Explain why not.

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**A. Drug name**

Dates of use

Dose and frequency

Did member experience any of the following?

☐ Adverse reaction

☐ Inadequate response

☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

---

---

**B. Drug name**

Dates of use

Dose and frequency

Did member experience any of the following?

☐ Adverse reaction

☐ Inadequate response

☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

---

---

**Note:** You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Strattera Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Strattera (atomoxetine). Additional information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

<b>Strattera request</b> (Check one or all that apply.) <input type="checkbox"/> Strattera 10 mg <input type="checkbox"/> Strattera 18 mg <input type="checkbox"/> Strattera 25 mg <input type="checkbox"/> Strattera 40 mg <input type="checkbox"/> Strattera 60 mg	Dose, frequency, and duration  <b>Note:</b> The manufacturer recommends an initial dose of 0.5 mg/kg/day for children and adolescents weighing < 70 kg with a target dose of 1.2 mg/kg/day. The maximum dose is 1.4 mg/kg/day or 100 mg, whichever is lower. In patients weighing more than 70 kg, the recommended initial dose is 40 mg daily with a targeted dose up to 80 mg. Daily dose of Strattera should not exceed 100 mg.  Indication (Check one or all that apply.) <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) <input type="checkbox"/> Other (Explain.)	Drug NDC (if known) or service code
Is member under the care of a psychiatrist or behavioral specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of psychiatrist or behavioral specialist _____		
Telephone no.: _____ Date of last visit: _____		
Please list all medications currently prescribed for this member for this condition. _____ _____		
Please describe your new treatment plan for managing this member's condition, including discontinuation of any medications as a result of the addition of Strattera. _____ _____		

## Medication information (cont.)

Has member tried other medications in the methylphenidate class (i.e., Concerta, Focalin, Metadate, Methylin, or Ritalin) to treat this condition? ☐ Yes. Complete box A. ☐ No. Explain why not. \_\_\_\_\_

A. Drug name	Dates of use	Dose and frequency
Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Other		
Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____		

Has member tried other medications in the amphetamine/dextroamphetamine class (i.e., Adderall or Dexedrine) to treat this condition? ☐ Yes. Complete box B. ☐ No. Explain why not. \_\_\_\_\_

B. Drug name	Dates of use	Dose and frequency
Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Other		
Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____		

Has member tried other non-stimulant medications to treat this condition?

☐ Yes. Complete box C. ☐ No. Explain why not. \_\_\_\_\_

C. Drug name	Dates of use	Dose and frequency
Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Intolerance <input type="checkbox"/> Other		
Briefly describe details of adverse reaction, inadequate response, intolerance, or other. _____		

**Note:** You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

## Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )
Address		City	State Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State Zip
E-mail address			Telephone no. ( )	Fax no. ( )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.)

Date



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax: 1-877-208-7428 Phone: 1-800-745-7318**

## Triptan Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Amerge, Frova, Imitrex tablets and nasal spray, Maxalt, Maxalt-MLT, Relpax and Zomig nasal spray. **PA is not needed for Axert, Zomig, or Zomig-ZMT for quantity requests less than or equal to six units per month or for Imitrex injections for quantity requests less than or equal to two units (four injections) per month.**

Additional information about triptans can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

Triptan request	Quantity request	Dose, frequency, and duration of requested drug	Drug NDC (if known)
<input type="checkbox"/> Amerge tablet <input type="checkbox"/> Axert tablet <input type="checkbox"/> Frova tablet <input type="checkbox"/> Imitrex injection <input type="checkbox"/> Imitrex nasal spray <input type="checkbox"/> Imitrex tablet <input type="checkbox"/> Maxalt tablet <input type="checkbox"/> Maxalt-MLT tablet <input type="checkbox"/> Relpax tablet <input type="checkbox"/> Zomig nasal spray <input type="checkbox"/> Zomig tablet <input type="checkbox"/> Zomig-ZMT tablet <input type="checkbox"/> Other: _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Indication for triptan requested (Check one.) <input type="checkbox"/> Acute treatment of migraine Frequency of migraine attacks (number/month) _____ Is member currently on migraine prophylaxis? <input type="checkbox"/> No. Explain why not. _____ <input type="checkbox"/> Yes. Specify agent(s), dose, and frequency. _____  <input type="checkbox"/> Other: Specify pertinent medical history, diagnostic studies, and/or laboratory tests. _____ _____ _____  Please attach supporting documentation (e.g., copies of medical records and/or office notes).	
<b>Has member tried the following triptans: Axert and Zomig, or Zomig-ZMT?</b> <input type="checkbox"/> Yes. Complete boxes A and B. <input type="checkbox"/> No. Explain why not. _____ _____ _____ _____		<b>A. Dates of Axert use</b> _____ <b>Dose and frequency</b> _____  Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other Briefly describe details of adverse reaction, inadequate response, or other. _____ _____ _____  Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).	
<b>Is the member under the care of a neurologist?</b> <input type="checkbox"/> Yes. <input type="checkbox"/> No.  <b>Name of neurologist</b> _____  <b>Telephone No.</b> _____  <b>Date of last visit or consult</b> _____		<b>B. Dates of Zomig or Zomig-ZMT use</b> _____ <b>Dose and frequency</b> _____  Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other Briefly describe details of adverse reaction, inadequate response, or other. _____ _____ _____  Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).	

Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber’s signature (Stamp not accepted.)

Date



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Brand-Name Drug Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prescribers must obtain PA from MassHealth for any brand-name multiple-source drug that has an FDA "A"-rated generic equivalent as identified by the **Approved Drug Products with Therapeutic Equivalence Evaluations** (also called the "Orange Book"). Additional information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

Last name	First name	MI	MassHealth member ID No.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

### Medication information

<b>Brand-name drug requested</b>	Dose, frequency, and duration of brand-name drug	Drug or service code
Diagnosis pertinent to requested medication		
<b>Has member tried a generic product?</b>		
<input type="checkbox"/> Yes. Provide the following information.		
<input type="checkbox"/> No. Explain why not.		
Drug name		
Dates of generic use	Dose and frequency	
Did member experience any of the following?		
<input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other		
Details of adverse reaction, inadequate response, or other:		

### Pharmacy information

Name	Pharmacy provider no.	Telephone No. ( )	Fax No. ( )
Address	City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA No.	
Address			City	State	Zip
E-mail address			Telephone No. (       )	Fax No. (       )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.)

Date





Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
P.O. Box 2586  
Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Drug Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Information about which drugs require PA can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth)

### Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) <b>f m</b>
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility			Height	Weight	

### Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code
Diagnosis and/or indication		
Goals of therapy for requested medication		
Has member tried other medications to treat this condition?		
<input type="checkbox"/> Yes. Provide the information to the right. You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).	<div>Drug name</div> <div>Dates of useDose and frequency</div> <div>Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other Briefly describe details of adverse reaction, inadequate response, or other.</div>	
<input type="checkbox"/> No. Explain why not.	<div>Drug name</div> <div>Dates of useDose and frequency</div> <div>Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other Briefly describe details of adverse reaction, inadequate response, or other.</div>	

## Medication information (cont.)

Explain medical necessity of requested drug.

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List all current medications.

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Other pertinent information:

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## Diagnostic studies and/or laboratory tests performed (include dates and results)

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## Pharmacy information

Name	Pharmacy provider no.	Telephone no. (     )	Fax no. (     )
Address		City	State     Zip

## Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State     Zip
E-mail address			Telephone no. (     )	Fax no. (     )

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
Prescriber's signature (Stamp not accepted.)

\_\_\_\_\_  
Date



*Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Division of Medical Assistance  
[www.state.ma.us/dma/](http://www.state.ma.us/dma/)*

### **MassHealth Pharmacy Program Anticonvulsant Initiative**

- 1. The following generic anticonvulsants DO NOT require prior authorization (PA). PA is required for the brand name product, unless a particular form of that drug does not have a FDA "A" rated generic equivalent. Brand name Dilantin (phenytoin), however, does not require PA.**

carbamazepine  
clonazepam  
clorazepate  
diazepam  
ethosuximide  
phenobarbital  
phenytoin  
primidone  
valproate  
valproic acid

- 2. The following brand name anticonvulsants, in any dosage form, DO NOT require PA:**

Carbatrol (carbamazepine)  
Celontin (methsuximide)  
Depakote (divalproex)  
Dilantin (phenytoin)  
Felbatol (felbamate)  
Lamictal (lamotrigine)  
Mebaral (mephobarbital)  
Peganone (ethotoin)  
Phenytek (phenytoin)  
Trileptal (oxcarbazepine)  
Zonegran (zonisamide)

- 3. The following anticonvulsants DO require prior authorization effective 6/2/03:**

Gabitril (tiagabine)	PA > 18 years
Keppra (levetiracetam)	PA
Neurontin (gabapentin)	PA > 18 years
Topamax (topiramate)	PA > 18 years



## MassHealth Pharmacy Program Antidepressant Initiative

### A. The following antidepressant drugs **DO NOT** require prior authorization (PA):

amoxapine	mirtazapine
bupropion	nefazodone
fluoxetine	paroxetine – No PA > 18 years
fluvoxamine	trazodone
MAO Inhibitors	tricyclic antidepressants
maprotiline	Wellbutrin SR (bupropion sustained release)

### B. The following antidepressant drugs **DO** require prior authorization:

mirtazapine, orally disintegrating tablet – PA (effective 05/03/04)	Symbyax (fluoxetine/olanzapine) – PA
Remeron (mirtazapine) – PA	Wellbutrin XL (bupropion extended-release) – PA
Remeron Sol Tab (mirtazapine, orally disintegrating tablet) – PA (effective 05/03/04)	

### C. The following antidepressant drugs **DO** require prior authorization, unless criteria D.i. and/or D.ii. below have been met:

Celexa (citalopram) – PA	Paxil CR (paroxetine controlled-release) – PA
Effexor (venlafaxine) – PA	Pexeva (paroxetine) – PA
Effexor-XR (venlafaxine extended-release) – PA	Prozac (fluoxetine) – PA
Lexapro (escitalopram) – PA	Prozac Weekly (fluoxetine) – PA
Luvox (fluvoxamine) – PA	Sarafem (fluoxetine) – PA
paroxetine – PA < 18 years	Serzone (nefazodone) – PA
Paxil (paroxetine) – PA	Zoloft (sertraline) – PA

### D. Antidepressant drug PA modifications for stable patients, treatment failure, and duplicative therapy:

#### i. Stable patients

**No PA will be required** for an antidepressant prescription (and the prescriber will not be required to submit a paper PA form) if, over the last six months, the patient has filled a prescription for a cumulative supply of at least 100 days of any antidepressant medication, **except** when the addition of this drug would constitute polypharmacy (see C. iii. below). \*

#### ii. Treatment failure

**Any antidepressant listed in Section B.** Prescriber must provide documentation that member has failed treatment with **at least** one generic selective serotonin reuptake inhibitor.

#### iii. Duplicative Therapy

**PA is required** when the patient has an overlap of 60 days or more in prescriptions for any dosage form of two or more of the following drugs:

Celexa (citalopram)	Paxil (paroxetine)
Effexor (venlafaxine)	Paxil CR (paroxetine controlled-release)
Effexor-XR (venlafaxine extended-release)	Pexeva (paroxetine)
fluoxetine	Prozac (fluoxetine)
fluvoxamine	Prozac Weekly (fluoxetine)
Lexapro (escitalopram)	Sarafem (fluoxetine)
Luvox (fluvoxamine)	Zoloft (sertraline)
paroxetine	

MassHealth encourages prescribers to use the Antidepressant Prior Authorization Request form when requesting prior authorization for any of the above antidepressants. See the Antidepressants Table for more information about selected antidepressants.

*\* Note: The decision on whether PA is required is based upon information available in the MassHealth pharmacy database. The MassHealth database contains member drug utilization information exclusive to MassHealth, and no other health plans*



## MassHealth Pharmacy Program Asthma Initiative

### 1. Respiratory inhalant products that DO NOT require prior authorization (PA):

#### Inhaled Short-Acting Beta-2 Agonists

albuterol (generic)  
metaproterenol (generic)  
inhalation solution

#### Inhaled Combination Products

Advair (fluticasone/salmeterol)  
DuoNeb (albuterol/ipratropium)  
Combivent (albuterol/ipratropium)

#### Inhaled Long-Acting Beta-2 Agonists

Foradil (formoterol)  
Serevent (salmeterol)

#### Miscellaneous Inhaled Products

Atrovent # (ipratropium)  
Intal # (cromolyn)  
Tilade (nedocromil)

#### Inhaled Corticosteroids

AeroBid (flunisolide)  
Azmecort (triamcinolone)  
Flovent (fluticasone)  
Qvar (beclomethasone)  
Pulmicort (budesonide)  
Vanceril (beclomethasone)

### 2. Respiratory inhalant products that DO require PA effective June 2, 2003:

#### Inhaled Beta-2 Agonists

Alupent (metaproterenol) inhaler  
Maxair (pirbuterol)  
Proventil (albuterol)  
Proventil HFA (albuterol)  
Ventolin (albuterol)  
Ventolin HFA (albuterol)  
Xopenex (levalbuterol)

#### Inhaled Corticosteroids

AeroBid-M (flunisolide)

3. Use of more than one canister per month of a short-acting beta-2 agonist may indicate inadequate control of asthma and the need for initiating or intensifying anti-inflammatory therapy.
4. The following oral asthma medications require PA (and the prescriber is required to submit a paper PA form) if, over the last six months, the member has not filled a prescription for an inhaled short- or long-acting beta-2 agonist or corticosteroid effective June 2, 2003. \*

Accolate (zafirlukast) PA > 16 years  
Singulair (montelukast) PA > 16 years  
Zyflo (zileuton) PA > 16 years

# This is a brand-name drug with FDA "A" rated-generic equivalents. PA is required for the brand, unless a particular form of that drug does not have an FDA "A" rated generic equivalent.

\*Note: The decision on whether PA is required is based upon information available in the MassHealth pharmacy database. The MassHealth database contains member drug utilization information exclusive to MassHealth, and no other health plans.



## **MassHealth Pharmacy Program Atypical Antipsychotic Initiative**

- 1. PA is required for most atypical antipsychotic duplicative therapy, which is defined as an overlap of 60 days or more in prescriptions (for any dosage form) of two or more of the following atypical antipsychotics:**
  - Abilify (aripiprazole)
  - Geodon (ziprasidone)
  - Risperdal (risperidone)
  - Seroquel (quetiapine)
  - Zyprexa (olanzapine)
- 2. Generic clozapine does not require prior authorization (PA) when prescribed either alone or in concert with another atypical antipsychotic. Brand name Clozaril requires PA because it has an FDA “A”-rated generic.**
- 3. Risperdal Consta (risperidone injection) does not require PA when prescribed either alone or in concert with another atypical antipsychotic.**
- 4. The following atypical antipsychotics require prior authorization:**
  - Fazaclo (clozapine, orally disintegrating tablet) – PA
  - Risperdal M (risperidone, orally disintegrating tablet) – PA
  - Symbyax (olanzapine/fluoxetine) – PA
  - Zyprexa Zydis (olanzapine, orally disintegrating tablet) – PA
  - Zyprexa IM (olanzapine injection) – PA

MassHealth encourages prescribers to use the Antipsychotic Prior Authorization Request form when requesting prior authorization for any of the above antipsychotics. See the Atypical Antipsychotics Table for more information about selected antipsychotics.

*\* Note: The decision on whether PA is required is based upon information available in the MassHealth pharmacy database. The MassHealth database contains member drug utilization information exclusive to MassHealth, and no other health plans.*



## MassHealth Pharmacy Program Pain Initiative

**1) The following schedule II long-acting narcotic analgesics will require prior authorization (PA) for dose effective September 1, 2004:**

levorphanol (Levo-Dromoran #) – PA > 32 mg/day  
methadone (Dolophine #, Methadose #) – PA > 120 mg/day  
morphine controlled-release (MS Contin #, Oramorph SR, generics) – PA > 360 mg/day  
morphine sustained-release (Kadian) – PA > 360 mg/day

**2) The following schedule II short-acting narcotic analgesics require PA for dose effective October 1, 2004:**

codeine – PA > 360 mg/day  
hydromorphone (Dilaudid #) – PA > 60 mg/day  
meperidine (Demerol #) – PA > 750 mg/day  
morphine immediate release (MS/L, MSIR, OMS, Roxanol, Roxanol-T) – PA > 360 mg/day  
oxycodone immediate release (Endocodone, Oxydose, OxyFast, Oxy IR, Roxicodone) – PA > 240 mg/day

**3) The following drugs will continue to require PA:**

butorphanol, nasal spray (Stadol nasal spray) – PA	morphine extended-release (Avinza) – PA
fentanyl transmucosal system (Actiq) – PA	oxycodone powder – PA
fentanyl transdermal system (Duragesic) – PA	oxycodone/acetaminophen (Percocet) – PA
hydromorphone powder – PA	oxycodone controlled release (OxyContin, generics) – PA
ketamine powder – PA	
levorphanol powder – PA	

# This is a brand-name drug with FDA “A”- rated-generic equivalents. PA is required for the brand, unless a particular form of that drug does not have an FDA “A”- rated generic equivalent.

**For fentanyl transdermal system (Duragesic) and oxycodone controlled release (OxyContin, generics):**

Members will be exempt from PA if a pharmacy received a paid claim for these drugs for the Member within the past 90 days and are filling no more than 30 patches/month or 200 mcg/hr of Duragesic (fentanyl transdermal system) or 90 tablets/month of OxyContin (oxycodone controlled release). Note: The decision on whether PA is required is based on information available in the MassHealth pharmacy database. The MassHealth database contains member drug utilization information exclusive to MassHealth, and no other health plans.



# MassHealth Quick Reference Guide

## Alpha-1 Adrenergic Blockers

doxazosin  
prazosin  
terazosin

Flomax — PA

Uroxatral — PA

## Angiotensin Converting Enzyme Inhibitors

benazepril  
captopril  
enalapril  
fosinopril  
lisinopril  
moexipril  
Accupril — PA  
Aceon — PA  
Altace — PA  
Mavik — PA

## Angiotensin II Receptor Antagonists

Atacand — PA  
Avapro — PA  
Benicar — PA  
Cozaar — PA  
Diovan — PA  
Micardis — PA  
Teveten — PA

## Anticonvulsants

carbamazepine  
clonazepam  
clorazepate  
diazepam  
ethosuximide  
gabapentin — PA > 18 yrs.

phenobarbital  
phenytoin  
primidone

valproate  
valproic acid

Carbatrol

Celontin

Depakote

Dilantin

Felbatol

Lamictal

Mebaral

Peganone

Trileptal

Zonegran

Gabitril — PA > 18 yrs.

Keppra — PA

Topamax — PA > 18 yrs.

## Antidepressants

bupropion  
bupropion SR  
citalopram  
fluoxetine

fluvoxamine

MAOIs

maprotiline

mirtazapine

nefazodone

paroxetine

TCAs

trazodone

Effexor — PA

Lexapro — PA

Paxil CR — PA

Prozac Weekly — PA

Sarafem — PA

Wellbutrin XL — PA

Zoloft — PA

## Antidiabetic Agents

acetohexamide  
chlorpropamide  
glipizide  
glipizide ER  
glyburide  
metformin  
metformin ER  
tolazamide  
tolbutamide

Actos

Avandia

Amaryl — PA

Diabeta — PA

Glyset — PA

Insulin, Prefilled Syr — PA

Prandin — PA

Precose — PA

Starlix — PA

## Antihistamines

brompheniramine  
chlorpheniramine  
diphenhydramine  
loratadine

Allegra — PA

Clarinet — PA

Zyrtec Syrup — PA > 12 yrs.  
except in LTC

## Antipsychotics

Abilify \*  
clozapine  
Fazaclo — PA  
Geodon\*  
Risperdal \*  
Risperdal M — PA  
Seroquel \*  
Zyprexa \*

Zyprexa IM — PA

Zyprexa Zydis — PA

\*PA required for polypharmacy  
(overlap of more than 60 days).

## Asthma

albuterol  
Advair  
Aerobid

Atrovent #

Azmacort

Combivent

Flovent

Foradil

Intal #

Pulmicort

Qvar

Serevent

Tilade

Vanceril

Aerobid-M — PA

Alupent — PA

Maxair — PA

Proventil HFA — PA

Ventolin HFA — PA

Xopenex — PA

## Beta Adrenergic Blocking Agents

acebutolol  
atenolol  
betaxolol  
bisoprolol  
esmolol  
labetalol  
nadolol  
pindolol  
propranolol  
sotalol  
timolol  
Inderal LA #  
Toprol XL

Cartrol — PA

Coreg — PA

Innopran XL — PA

Levatol — PA

## Calcium Channel Blocking Agents

diltiazem  
nicardipine  
nifedipine  
verapamil  
Nimotop

Dynacirc — PA

Norvasc — PA

Plendil — PA

Sular — PA

Vasacor — PA

## COX-2 NSAIDs

Bextra — PA < 60 yrs.

Celebrex — PA < 60 yrs.  
Generic non-selective NSAID  
formulations do not require prior  
authorization.

## H<sub>2</sub> Antagonists

cimetidine  
famotidine  
nizatidine — PA  
ranitidine

## Hypnotics

estazolam — Q  
flurazepam — Q  
temazepam — Q  
triazolam — Q  
Ambien — Q  
Sonata — Q  
PA > 10 units/ month for above  
hypnotics.

## Leukotrienes

Accolate — PA > 16 yrs.  
Singulair — PA > 16 yrs.  
Zyflo — PA > 16 yrs.

## Narcotic Agonist Analgesics

Duragesic — PA  
levorphanol — Q  
methadone — Q  
morphine CR — Q  
morphine SR — Q  
oxycodone ER — PA  
Oxycontin — PA

## Nasal Steroids

flunisolide — Q

Beconase AQ — Q

Flonase — Q

Nasacort — Q

Nasacort AQ — Q

Nasarel — Q

Nasonex — Q

Rhinocort Aqua — Q

PA > 1 unit/month for all except  
Rhinocort Aqua (PA > 1unit/  
2months).

## Proton Pump Inhibitors

Protonix  
omeprazole — PA  
Aciphex — PA  
Nexium — PA  
Prevacid — PA > 16 yrs. (except  
for suspension for LTC)

## Statins

lovastatin — Q  
Crestor — Q  
Lescol — Q  
Lescol XL — Q  
Lipitor — Q  
Advicor — PA  
Altacor — PA  
Pravachol — PA  
Zocor — PA  
Quantity limit 30 units/month  
for all statins.

## Triptans

Amerge — PA  
Axert — Q  
Frova — PA  
Imitrex Tab — PA  
Imitrex Nasal — PA  
Imitrex Inj. — Q  
Maxalt — PA  
Relpax — PA  
Zomig — Q  
PA > 6 units/month for Axert  
and Zomig and 4 injs./month for  
Imitrex inj.

December 2004

This document does not represent the complete MassHealth Drug List. For more information, please visit the MassHealth website at [www.mass.gov/druglist](http://www.mass.gov/druglist).

MassHealth may update the Drug List as frequently as twice a month. MassHealth will update the List as necessary on the first business day of the month or 14 calendar days later or both.

PA denotes prior authorization is required. Prior-authorization forms can be found at [www.mass.gov/druglist](http://www.mass.gov/druglist)

# This is a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug does not have an FDA "A"-rated generic equivalent.

Q PA is required to exceed certain quantity limits.

LTC denotes Long Term Care



## Nonlegend Drug List

This page lists the only nonlegend drugs that are covered by MassHealth without prior authorization. All other nonlegend drugs except insulins require prior authorization. Please refer to 130 CMR 406.411(A) and 406.412(A)(2) for further information on nonlegend drugs.

Insulins that are available without prior authorization are listed in the MassHealth Drug List. All insulins are covered for members at home, in nursing facilities, or in rest homes.

The items in this appendix are listed alphabetically by therapeutic class, then by the generic name of the drug or drug ingredients. In general, MassHealth pays only for **generic** versions of these nonlegend drugs, singly or in combination, regardless of strength or dosage form. Combination products that contain active ingredients that are not included in this list require prior authorization.

Notwithstanding the above, MassHealth may provide reimbursement for a brand-name nonlegend product if that product meets the definition of medical necessity at 130 CMR 406.204. Any such product for which reimbursement is permitted appears on this list by brand name.

### Analgesics:

acetaminophen  
aspirin  
aspirin with buffers  
capsaicin  
ibuprofen  
ketoprofen  
naproxen

### Antihistamines/ Decongestants:

brompheniramine  
chlorpheniramine  
diphenhydramine  
loratadine  
pseudoephedrine

### Antimicrobials, Topical:

bacitracin  
chlorhexidine gluconate  
clotrimazole  
hydrogen peroxide  
iodine  
isopropyl alcohol  
miconazole  
neomycin  
polymixin B  
povidone  
tolnaftate

### Contraceptives, Topical:

nonoxynol-9

### Gastrointestinal Products:

aluminum carbonate  
aluminum hydroxide  
bisacodyl  
bismuth subsalicylate  
calcium carbonate  
casanthranol  
cimetidine  
cod liver oil  
docusate sodium  
famotidine  
kaolin/pectin  
loperamide  
magaldrate  
magnesium citrate  
magnesium hydroxide  
magnesium trisilicate  
meclizine  
mineral oil  
psyllium  
ranitidine  
senna  
simethicone  
sodium bicarbonate

### Vitamins and Nutrients:

ascorbic acid  
calcium carbonate  
calcium citrate  
calcium gluconate  
calcium phosphate  
cyanocobalamin  
electrolyte solution (pediatric)  
ferrous fumarate  
ferrous gluconate  
ferrous sulfate  
folic acid

magnesium gluconate  
multivitamins, N.F.  
multivitamins with minerals  
niacin  
niacinamide  
nicotinic acid  
pediatric vitamins  
prenatal vitamins  
pyridoxine (vitamin B<sub>6</sub>)  
retinol (vitamin A)  
riboflavin  
thiamine  
vitamin B complex  
vitamin D

### Miscellaneous Products:

A&D ointment  
ammonium lactate 12%  
artificial tears  
benzoyl peroxide  
calamine lotion  
carbamide peroxide  
colloidal oatmeal  
hydrocortisone  
lanolin  
permethrin  
petrolatum  
selenium sulfide  
sodium chloride solution  
for inhalation  
water for inhalation  
witch hazel  
zinc oxide

## 10 Tips for a Good Night's Sleep

1. **Keep consistent bedtimes and wake times seven days a week** (even after a "bad" night).
2. A person should only stay in bed equal to the number of hours of sleep they are achieving per night (for example, if you are getting six hours of sleep per night you should plan bedtime and wake time as six hours apart). **Many insomniacs spend far too much time in bed**, attempting to "squeeze" out a few more minutes of sleep.
3. If you have difficulty getting to sleep within 20 minutes, **get out of bed** and do something relaxing and distracting. For many people this is reading. **Do not do housework, bills, work, or anything that is too stimulating within two hours of bedtime or during a nighttime awakening.**
4. Although some people's insomnia is helped by a **nap** at midday, for most, it **will interfere with falling asleep that night.**
5. **Avoid alcohol** within five hours of bedtime. Alcohol is a poor hypnotic and causes nighttime awakenings.
6. **Avoid caffeine** (coffee, tea, soda, chocolate) after noon. Even if it doesn't prevent you from falling asleep, it can cause shallow sleep or nighttime awakenings.
7. **Avoid** going to bed on either an **empty stomach or a full stomach.** A light snack may be of value.
8. **Bedrooms should be quiet, safe, and relaxing.** Clocks should face away from the bed, so as not to "count down" the minutes until morning.
9. **Daily exercise** will improve insomnia, although the effects may not be immediate.
10. **Schedule "worry time"** earlier in the day, so as to consider the day's problems and find some resolution **before** getting into bed.

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The MassHealth Drug List is updated monthly, as needed.  
Check our Web site for the most up-to-date information.

**[www.mass.gov/druglist](http://www.mass.gov/druglist)**

Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
MassHealth